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MEDICAL JOURNAL OF AUSTRALIA

VOL. II.—11TH YEAR. SYDNEY: SATURDAY, AUGUST 2, 1924. No. 5.

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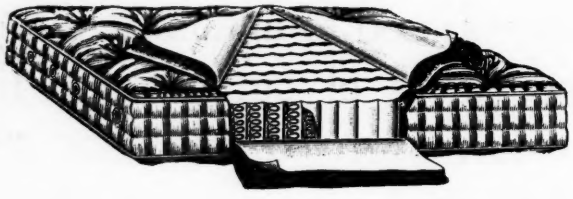

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THE MEDICAL JOURNAL OF AUSTRALIA

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CHRONIC URETHRITIS.[1]

By L. E. ELLIS, M.B., Ch.M. (Sydney),
Honorary Medical Officer for Venereal Diseases, Royal Prince Alfred Hospital, Sydney.

Introduction

I HAVE chosen the subject of chronic urethritis for my paper for three reasons: (i.) Chronic urethritis is a common disease; everyday we see the man with a gleet who has had gonorrhœa but has it no longer, the man with filaments in his urine; (ii.) until lately it has been wrapped in obscurity and (iii.) unless treated upon sound lines it may persist for years. Much of the subject matter of my paper is old, some of it is new. I have woven the new with the old in order to make the fabric complete.

Ætiology.

Chronic urethritis is not gonorrhœa. Its association with gonorrhœa has been the main confusing factor. Gonorrhœa may persist for a long time owing to an undiscovered focus of infection, needing only detection and correct treatment of the focus to insure a cure; but this prolonged gonorrhœa is not chronic urethritis which latter owes its persistence to anatomical lesions and in its pathology constitutes a separate entity quite distinct from gonorrhœa. Gonorrhœa is the most frequent predecessor to chronic urethritis, but it predeceases it. Some cases of chronic urethritis are not even preceded by gonorrhœa, but owe their origin to other causes such as non-gonococcal urethritis, chemical or mechanical injury or to genital abuse. Again, although gonorrhœa is the most frequent precursor of chronic urethritis, the gonococci die out whilst chronic urethritis persists. Gall examining a large number of cases found that gonococci diminish and disappear following a regular curve corresponding to the age of the discharge. A similar disappearance of gonococci is seen in gonorrhœal Bartholinitis and pyosalpinx. This spontaneous disappearance of gonococci from the urethra has been attributed to the phagocytic action of the epithelial cells. Clinically also patients with chronic urethritis are seen daily from whom gonococci cannot be obtained.

If then gonococci are not responsible for the persistence of the lesions of chronic urethritis, what is? Pus accompanies chronic urethritis and organisms are a *sine qua non* for the occurrence of pus. In some cases secondary organisms are associated with chronic urethritis and to them has been attributed the causative agency for the trouble, but frequently

[1] Read at a meeting of the New South Wales Branch of the British Medical Association on May 29, 1924.

cases of chronic urethritis occur in which neither gonococci nor other organisms are found and the condition is apparently amicrobic. This amicrobism is not real, the apparent absence being due according to Noguès to two facts: First that the majority of these organisms escape our usual methods of investigation and demand a special technique and second that they are deeply situated in the pathological productions to which they have given birth. With regard to the first the study of anaerobes has thrown light upon this subject. Jungano, working upon the urethral flora, took eight cases of amicrobic urethritis in which no cultures upon ordinary media were obtained. Nevertheless on culturing the secretions on media deprived of air he obtained cultures of anaerobic organisms in the whole eight cases, one of the organisms being a small staphylococcus.

With regard to the second, Jungano showed the sheltering rôle of the urethral glands. In six cases in which microscopical examination of the discharge revealed the presence of organisms, he made cultures from the drop and filaments; he then washed out the urethra with sterile water and immediately afterwards massaged the urethral glands upon a sound and cultured the resultant expression. In these second cultures he found always a richer flora than in the first. Moreover, using aerobic and anaerobic media, he obtained from both urethral secretions before and after the massage richer and more varied growth in the anaerobic tubes. These experiments explain the apparent absence of organisms from the pus of chronic urethritis and the persistence of the trouble.

Pathological Anatomy.

In chronic urethritis the usual lesions of chronic inflammation occur, merely modified by local conditions. The various structures that go to constitute the urethra, take part in this inflammation. The epithelial cells proliferate and become flattened and as a result the epithelial lining becomes greatly thickned.

In the sub-epithelial connective tissue small cell infiltration occurs keeping step more or less with the epithelial changes. The stage of small cell infiltration does not last long at any rate in the anterior portion of the urethra, but tends to undergo fibrous transformation, the resultant tissue being a sclerosis or hard infiltration or, if extensive and deep, a stricture.

In the *corpus spongiosum* the change is also a small cell infiltration, the trabeculæ becoming thickened and the areolæ correspondingly reduced. This process may advance to such an extent that the *corpus spongiosum* ceases to exist and is replaced by a total annular sclerosis and a stricture is the result. The difference between chronic urethritis and a stricture is only one of degree; in the former the lesions are small and scattered, in the latter extensive and deep.

The glands and lacunæ are modified by the inflammation. The lacunæ, being merely depressions in the mucous membrane, undergo similar changes to that structure and contain pus; their orifices may become obliterated and this results in the formation of cysts. The glands because of their deep situation play an important part in chronic urethritis. Within the glands there is proliferation of the epithelial lining and around them a small cell infiltration which may develope to such an extent as to shut off the ducts, thus producing cysts. The rôle that the glands play in the extension in depth of chronic urethritis is considerable and it is through them that the *corpus spongiosum* becomes infiltrated.

The membranous urethra enjoys relative immunity in chronic urethritis. Out of thirty-two cases of chronic urethritis in which *post mortem* examinations were made, Finger found lesions of this region in two only and these were slight.

The lesions of the posterior portion of the urethra differ considerably from those of the anterior. The start is the same in that a small cell infiltration occurs, but whereas in the anterior portion of the urethra the tendency is for this soft infiltration to undergo fibrous transformation, in the posterior portion there is no such tendency. Soft infiltration persists as the characteristic lesion of posterior urethritis. What is the reason for this persistence as soft infiltration? To me it seems that the constant stimulus supplied by the discharges from neighbouring organs, the prostate and seminal vesicles which are generally morbidly associated with the urethra in chronic posterior urethritis, prevents the tissues from getting the rest necessary for fibrous development. This soft infiltration may involve any part of the posterior portion of the urethra, but is especially prone to affect the *veru montanum* which becomes swollen and often deformed and is frequently the seat of polypoid formations. These psuedo-polypi may be implanted upon any part of the mucosa; they may be few and slender or may be numerous and massive. These polypoid formations are interesting. Roth and Mayer in a large number of patients found them in 20% of those with chronic posterior urethritis. In Paris where I had the opportunity of seeing a large number of urethroscopic examinations, it surprised me to see so many patients with polypi and it no less surprised me to see how rapidly and perfectly they cleared up under high frequency treatment. These polypoid formations are not real polypi such as are met with in the bladder. Real polypi do occasionally occur in the posterior portion of the urethra, but only in its posterior end which has the same embryological origin as the bladder. The pseudo-polypi are not new growths, but rather the usual soft infiltration taking on hypertrophic action under the influence of special causes, such as discharges from neighbouring organs. Hence the importance of not neglecting these organs in the treatment of chronic urethritis. Soft infiltration in chronic posterior urethritis is accompanied by glandular lesions which do not differ from those of the anterior portion of the urethra. The infiltration may involve the orifices of the ejaculatory ducts and give rise to ejaculatory troubles.

Stricture of the posterior portion of the urethra is not common. In the first place hard infiltration is not the rule as in thhe anterior portion; also this region has no spongy tissue and the importance

of this tissue in stricture formation has already been indicated. Still strictures do occur and may be very pronounced.

Symptoms.

The symptoms of chronic urethritis may be slight or pronounced. They may be classed as urinary, genital and general.

The main urinary symptom is urgent and frequent micturition especially diurnal; in cystitis the frequency is nocturnal.

The genital symptoms have to do with erection and ejaculation. Erection may sometimes be completely at fault, there being then complete impotence, but generally the power of erection exists but is inopportune; the patient has prolonged, may be painful erections amounting even to priapism, but when he attempts coitus he may be unable to develope the necessary rigidity. Ejaculation may also be disordered. There may be hæmospermia generally from a lesion of the ejaculatory ducts or orifices. More frequently it is disordered ejaculation which complicates chronic urethritis. When an almost moderate erection encourages an attempt at coitus the semen escapes in a dribble without force or pleasure may be before or immediately after introduction. Sometimes on the contrary ejaculation may be delayed beyond the limits of endurance. Nocturnal emissions are prone to occur and there may be more than one during the same night.

The general symptoms in some cases amount to all the manifestations of neurasthenia. The body may suffer and the patient become unfit for any labour and reach a state out of all proportion to his lesion. The urine may become altered and manifest a decrease of chlorides and urea and an increase of phosphates. All these symptoms were attributed at one time to neurasthenia, but since the introduction of the urethroscope the neurasthenic field has considerably contracted. Some authors go so far as to assert that genito-urinary neurasthenia does not exist and that the failure to explain certain symptoms by definite lesions is merely an expression of our ignorance and that this group will be found to disappear as our means of investigation are perfected and our knowledge precised.

Physical Signs.

The physical signs are important and may help to localize the seat of trouble. They are: (i.) The discharge, (ii.) turbidity of the urine and filaments and (iii.) anatomical modifications of the urethra.

The discharge is generally small and there may be stickiness only; it varies in colour, the morning discharge being mostly more abundant, thicker and more coloured.

The turbidity of the urine indicates an epithelial and sub-epithelial inflammation, whereas filaments indicate glandular involvement. Considerable localizing information may be obtained from the filaments by the three glasses and other tests.

Anatomical modifications of the urethra consist of thickening of the walls, increase in size of the glands and diminution in calibre of the urethra and may be investigated by palpation, exploration by means of bougies or sounds, urethrometry and urethroscopy. Time will only permit of dealing with the last.

Urethroscopic Appearances in Chronic Anterior Urethritis.

In soft infiltration the mucous membrane is red, swollen and œdematous and bulges into the lumen of the tube. The longitudinal folds are represented by three or four great masses separated by scarcely visible sulci. The surface loses its polish, becomes roughened and easily bleeds. The lacunæ are surrounded by a red zone while Littré glands are invisible. This infiltration is not generally diffuse, but scattered and merges insensibly with the surrounding healthy mucosa or with patches of hard infiltration. Because of the œdema pitting occurs upon withdrawing the urethroscopic tube.

In hard infiltration the appearance is different, the colour varies from dark red to dull white according to the age of lesion. The lumen of the urethra may remain patent and may be asymmetrical, the urethroscopic funnel is elongated, the longitudinal folds are reduced and may entirely disappear. The appearance of the glands varies, sometimes they are isolated and may be the centre of a zone of infiltration, sometimes they appear as red prominences, sometimes as vesicles full of fluid. When deeply situated they may be invisible and can only be felt externally. If they open directly on to the surface of the urethra, they are seen to exude a thick pus. The lacunæ are outlined in red.

Urethroscopic Appearances in Chronic Posterior Urethritis.

The urethroscopic appearances in chronic posterior urethritis vary with the stage of evolution of the affection. They are chiefly located in the part between the neck of the bladder and the urethral crest in front of the *veru montanum.* In the first phase there is merely congestion, sometimes affecting the whole of the posterior portion of the urethra, sometimes localized to irregular patches with healthy mucous membrane between. More often the congestion is accompanied by œdema; the mucous membrane is then red and swollen and bulges into the lumen of the tube and the surface bleeds easily. There are all degrees of soft infiltration. Sometimes on the surface of this infiltrated mucosa small transparent vesicles can be seen, sometimes few and scattered, sometimes massed, the whole having an appearance similar to bullous œdema of the bladder. In a more advanced stage these vesicles are replaced by papules and the papules may become elongated to such an extent as to take on a polypoid form and sometimes this polypoid formation predominates, definite polypoid masses springing from each lateral wall to meet in the middle of the urethroscopic field. Finally lesions of hard infiltration may be seen, especially near the neck of the bladder. These lesions have the usual grey, bloodless, cardboard-like characteristics of hard infiltration.

Similar lesions to those that occur in the posterior portion of the urethra, may be seen on the *veru montanum.*

The membranous urethra, although less often affected, commonly presents traces of glandular infection.

Diagnosis.

The diagnosis of chronic urethritis is made by the exclusion of gonorrhœa by the usual tests and by the presence of the symptoms and signs already given.

Treatment.

Treatment of chronic urethritis may be prophylactic or curative.

Prophylactic Treatment.

Prophylactic treatment is essentially correct treatment during the gonococcic phase, such as care and sterility in lavage, avoidance of injections and home treatment, avoidance of instrumentations during the acute stage, careful living, avoidance of faulty suspensory bandages causing pressure upon the urethra and avoidance of secondary infection.

Curative Treatment.

The curative treatment of chronic urethritis is essentially urethroscopic after the necessary preliminary dilatation. The urethroscopic examination should be thorough and embrace the whole urethra from bladder neck to meatus. The urethroscopic tube used (I am speaking of a Luy's urethroscope which I use) should be of fair size such as "54" or "56" to give a good sized field. To use this tube we must dilate the urethra to at least two sizes larger to avoid bleeding and other troubles. Three or four weeks would be required for this dilatation, but that time would not be wasted as the bi-weekly lavage and dilatation, combined with rectification of prostatic, vesicular and other faults, are in themselves excellent treatment for the condition and by the time dilatation is complete the cure may be well on the way and only need the finishing touches through the urethroscopic tube. Dilatation does not merely act mechanically. Its main action is dynamic favouring transformation of the pathological tissue. The contact activates the local circulation and promotes phagocytosis which favours the absorption of the inflammatory exudate. It does more: under the influence of this foreign body the muscular fibres contract. Such contractions have a salutary effect upon vascularization, but especially upon glandular evacuation.

The line of urethroscopic treatment I follow is that which I saw practised with excellent results by Dr. Gautier in Paris and is based upon the particular lesions as revealed by the urethroscope. Briefly it is as follows: (i.) For lacunitis, the cautery; (ii.) for glandular abscesses or cysts, the knife or cautery; (iii.) for hard infiltration, dilatation; (iv.) for congestion and slight infiltration, touching with 20% solution of silver nitrate; (v.) for small scattered œdematous patches, the cautery or high frequency current; (vi.) for marked extensive and polypoid lesions, high frequency current. The use of the cautery in these last lesions would be wrong. In the first place the duration of the treatment is long and in the second place the close scarrings from repeated cauterizations may lead to the development of a stricture years later. The high frequency spark on the contrary gives rapid results and leaves only a supple and invisible cicatrix.

In using the high frequency current for urethral lesions the flexible ended diathermic sound is not in contact with the lesion but about two millimetres removed from it, electro-coagulation not being aimed at but only the effect of the spark. A white superficial scar results which disappears in the course of a fortnight. The applications may be made weekly, one wall only being dealt with at each sitting and the effect of the previous treatment being watched.

I saw much high frequency work with Dr. Gautier and was much impressed by the rapid disappearance of the lesions.

Such are the main lines of treatment of chronic urethritis and their adoption is generally followed by disappearance of the drop and filaments and results in a happier frame of mind, a brighter outlook and a general improvement in health.

EXTRACTION OF FOREIGN BODIES FROM THE EYE.[1]

By R. B. NORTH, M.B., Ch.M. (Sydney), D.O.M.S., R.C.P and S. (England),
Sydney.

IN order to open the discussion on extraction of foreign bodies from the eyeball it will be necessary for me to touch on a number of points which are generally accepted and familiar to those present, in addition to any controversial matter which may be introduced. This course, I hope, may help to systematize the consideration of the subject.

When a patient presents himself with a penetrating wound of the eyeball or neighbouring structures, it is necessary to determine whether the presence of a foreign body in the eyeball is possible or probable. If the conclusion is arrived at from the circumstances of the case that the presence of a foreign body in the eyeball is a possibility, what is to be the further procedure in investigating the case? Is it to consist in writing an X-ray sheet and dismissing the patient until the X-ray report arrives, as is sometimes done? This course is advocated only in those cases in which the evidence of the presence of a foreign body is very doubtful. When it is probable that a foreign body is present, a very careful inquiry into the circumstances surrounding the accident will often give useful information as to the position of the patient's eye, the probable size, the projectile force and the probable direction taken by the foreign body. This information, together with the situation and shape of the aperture of entry, the sensitiveness of certain portions of the eye to touch, the presence of a circumscribed scotoma in the field of vision, sometimes enables us to form an approximate idea of its position in the eyeball.

During the time immediately succeeding the injury before cloudiness of the media developes

[1] Read at a meeting of the Ophthalmological Society of New South Wales on April 2, 1924.

and before the foreign body is surrounded with exudate, its presence may be discovered by use of the ophthalmoscope.

If the foreign body has pasesd through the cornea, the wound of entry even if very minute can always be found; it may escape detection if in the sclerotic.

A hole in the iris is of great diagnostic value, since it rarely occurs except as the result of perforation by a foreign body.

Consideration of the manner of production of the accident will frequently enable us to form a fairly accurate opinion as to whether the foreign body is magnetizable or not.

When a foreign body enters the eye during the use of a steel implement on stone, it is almost always a particle of steel which enters and not a piece of stone.

MAGNETIZABLE FOREIGN BODIES.

Foreign Bodies in the Posterior Segment.

With certain exceptions, which will be mentioned later, it is advocated that in dealing with magnetizable foreign bodies in the posterior segment of the eyeball, if the patient be seen shortly after the injury, an attempt should at once be made to extract the foreign body by the anterior route by means of the giant magnet and that valuable time should not be lost by waiting for an X-ray localization. If the latter course be adopted the foreign body is becoming surrounded with exudate during the delay, this renders its removal more difficult and other changes are taking place which render the prognosis more unfavourable. An X-ray localization will usually mean delaying the operation of removal until the following day at least. By this time the eye will have become red and tender; this will make any manipulation under local anæsthesia more painful and hence the operation more difficult.

The technique advocated is based on the work of Goulden and Whiting, reported in *The British Journal of Ophthalmology*, January, 1917, and since then largely adopted in many hospitals. The technique was developed from experience gained in dealing with a very large number of war injuries. I propose to give an outline of their technique with some slight modifications.

The wound of entry, be it corneal or scleral, is disregarded from the point of view of extraction, unless there be a large unhealed wound. Such a wound indicates the presence in the vitreous of a large foreign body which it would be hazardous to remove by any other path than through the wound of entry.

The method adopted is to draw the foreign body forward through the suspensory ligament of the lens into the posterior chamber and then through the pupil into the anterior chamber. This is done by means of a giant magnet, either the Haab or the Mellinger. The foreign body is then removed from the anterior chamber through a suitable corneal incision by means of the small magnet. The assistance given by an X-ray localization is by no means essential to successful treatment; if the localization is likely to involve more than two or three hours' delay it should be omitted.

The patient may be operated on sitting up or lying down. The eye must be under the influence of atropine. The illumination is carefully arranged. The magnet point should be actually in contact with the cornea at or slightly above the centre. The current is turned on and the strength gradually increased. If the foreign body does not appear, the current is turned off and the full strength is suddenly applied so as to disengage the foreign body from its bed. If this does not succeed, the magnet is applied to the centre of the cornea and the current rapidly switched on and off; this is done alternately with a series of long pulls and should be persisted in for five or more minutes. The foreign body may sometimes be loosened by applying the magnet to various points of the sclera, so as to pull the foreign body in various directions.

Sometimes the foreign body comes through the vitreous, slips round the posterior surface of the lens and suddenly appears quite free in the anterior chamber. This is the ideal result. Usually the foreign body shows its presence in the posterior chamber by pushing the iris before it. As soon as the bulging of the iris is noticed, the current must be cut off to avoid tangling the particle in the iris. The patient is then told to turn the eye in the direction in which the bulging occurred (usually below) and the magnet is then applied to the margin of the cornea on the opposite side (usually above). The current is then switched on and the foreign body slips through the pupil to the posterior surface of the cornea. The current is maintained and the patient is told to look upwards so that the foreign body is drawn to the bottom of the anterior chamber, the most suitable position for removal by the hand magnet.

If the foreign body does not come easily through the pupil, it is probably somewhat entangled in the iris. In this case the magnet point should be applied further back on the sclera and the foreign body will usually become free.

The presence of a small corneal or corneo-scleral wound with prolapse of the iris does not alter the technique. No attempt should be made to withdraw the foreign body through the wound.

When the foreign body is brought forward and deposited in the lower angle of the anterior chamber, the next step is the removal from the eye. If the eye is red and tender, a general anæsthetic must sometimes be used or a subconjunctival injection may be sufficient, otherwise local anæsthesia is employed. A keratome incision is made directly above, three millimetres below the limbus, the point of the blade is directed towards the foreign body and the incision made without lateral movement (a sufficiently large keratome should be used to make this possible). In this way a valvular section will be made, which on withdrawal of the keratome will prevent the escape of aqueous. The width of the incision is determined by the size of the foreign body. The keratome is withdrawn rapidly but smoothly and precisely in the plane of its insertion:

at the same moment the grasp of the conjunctiva is released.

The hand magnet is taken and the point of the terminal is placed outside the cornea and immediately over the foreign body, which is then drawn along the posterior surface of the cornea to the corneal section. The posterior lip of the wound is then depressed with the pole and the foreign body is drawn towards it and out of the wound. During the whole manœuvre the eye must not be touched with fixation forceps or aqueous will probably be lost. The iris repositor is then used if there is any tendency to prolapse.

If the aqueous be lost, the foreign body cannot be withdrawn in this manner; in this case the anterior chamber may be filled with normal saline and the foreign body removed as before. Another method is to pass a flat pole into the anterior chamber (the current being turned off); this is then manœuvred over or round the iris into contact with the foreign body which is gently removed.

Foreign Bodies in the Anterior Chamber.

When the foreign body is lying free in the anterior chamber, the operation is carried out as above described when the patient is first seen. The giant magnet is not used.

Foreign Bodies in the Iris.

If the foreign body is entangled in the iris, iridectomy must be done and the foreign body removed with portion of the iris.

Foreign Bodies in the Lens.

If the foreign body is in the lens and the eye shows no sign of infection, operation for its removal should be deferred until the cataract is also ready for removal. If the lens be considerably broken up, the foreign body should be brought forward by the giant magnet and removed as described; the operation being completed by washing out as much soft lens matter as possible. If the eye be infected, operation should be undertaken at once and the anterior chamber thoroughly irrigated with normal saline solution at 37.7° C. (100° F.).

Choice of Method.

The cases in which the anterior route is not recommended are:

(i.) When there is a large unhealed wound of entry. Here the wound should be enlarged slightly and the foreign body extracted through it.

(ii.) When a large foreign body is present. Here it would be dangerous to attempt to draw it through the circumlental space.

(iii.) Also in certain cases when there is a small foreign body present, when the wound is in an accessible portion of the sclera behind the ciliary region and when the foreign body may be withdrawn by enlarging the wound slightly, as when the foreign body is discovered lying just inside the wound.

(iv.) When the foreign body fails to come forward by the anterior method, although it is known that a magentizable foreign body is present.

In these cases the scleral or posterior method should be used. It is not considered necessary to describe the technique of this method here.

The objections to the scleral route of extraction for ordinary cases are: (i.) The delay necessary for X-ray localization; (ii.) unreliability of X-ray localization; (iii.) much greater risk of subsequent detachment of the retina; (iv.) unnecessary opening of the eyeball in case of non-magnetizable foreign bodies. The anterior route as described is also very useful when it is impossible to guess whether a foreign body is or is not magnetizable. The large magnet is used to try to draw the foreign body forward into the anterior chamber, whereas to make an incision into the sclera would cause fresh and useless trauma, especially if the foreign body proved to be not magnetizable.

Non-Magnetizable Foreign Bodies.

The removal of a non-magnetic foreign body with preservation of useful vision is extremely difficult unless the foreign body is visible from the front. It may be possible to remove such a foreign body with portion of the iris, or with a traumatic cataract which it has caused.

Generally speaking, if a foreign body in the vitreous chamber consists of copper or other chemically irritating material, an attempt should be made to remove it; if it consists of glass or porcelain or other chemically inactive substance it should be left alone.

FOREIGN BODIES IN THE EYE AND THEIR REMOVAL.[1]

By HUGH G. ALLEN, M.B., Ch.M. (Sydney),
Honorary Ophthalmic Surgeon, Newcastle Hospital, New South Wales.

IN the first place let me say how pleased I am to have had the opportunity of attending this meeting of the New South Wales Ophthalmological Society, of meeting some old friends of my student days and renewing an acquaintance with my colleagues of the medical profession in Sydney.

The subject for discussion this evening is a particularly interesting one, especially so as you realize I come from an industrial centre where perforating wounds of the eye are very common and the presence of a foreign body in the globe is a condition we are frequently called upon to treat.

I think it is the usual experience of ophthalmic surgeons that they do not see a great number of these cases in hospital during their training, and unless they are particularly fortunate in having had a few of them to deal with, they are apt to start practice with only a limited knowledge of the best methods of dealing with these emergencies.

Perforating wounds of the eyeball with foreign bodies embedded in the tissues of the eye at the best are not particularly satisfactory cases and a guarded prognosis must always be given. In the first place the amount of damage done by the foreign body, whether it is extracted successfully or otherwise, often means the loss of the eye. Again, a per-

[1] Read at a meeting of the Ophthalmological Society of New South Wales on April 2, 1924.

fectly successful operation with removal of the foreign body may afterwards result in loss of vision from subsequent degeneration and inflammatory changes, *exempli gratia* detached retina, vitreous and lens opacities, *retinitis proliferans et cetera*. When we consider the nature of these accidents, the sepsis which is introduced into the eye along with the foreing bodies and the difficulties which are met with at times in removing them, it is not to be wondered at that the results at best are, as I stated above, not particularly satisfactory. I admit we get our brilliant result at times, that a lot depends on the manner in which any operative measures are employed, but factors over which the ophthalmic surgeon has no control often direct the course of the injury and, although I suppose I deal with a large percentage of these traumatic cases in the Newcastle district, I always regard them with considerable gravity and as a cause of much anxiety.

There are the two schools of action in dealing with these particular conditions.

One lot of ophthalmic surgeons advocate extraction of magnetizable foreign bodies by the anterior route, *id est* bringing the foreign body forward into the anterior chamber by the Haab or Mellinger magnet and removing it either by the large or small electro-magnet.

Members of the other school advocate removal by the posterior route, *id est* through a scleral incision as near as possible to the situation of the foreign body either by placing the electro-magnet over the wound or by introducing the point slightly into the vitreous.

At the outset I must say I personally advocate the posterior route with certain restrictions. We are apt to become followers of any particular method according to the results we obtain and very often one practitioner will advocate one method, because he does not use or know the other. This is my reason for saying that I follow the posterior method with certain restrictions. I am convinced the Haab method of extraction or the Mellinger by the anterior route is an excellent method of dealing with many cases, but when the foreign body is drawn forward into the anterior chamber, we still have to deal with it there by a corneal incision and introduction of a smaller electro-magnet or the application of the large magnet itself. In very many cases the iris is entangled with the foreign body and iridectomy has to be performed. In this case the cosmetic appearance of the eye is lost. Again, I contend it is often a very difficult matter to bring a foreign body from the posterior portion of the eye to the anterior chamber around the pupillary border of the iris without causing considerable traumatism to the iris and to the lens, more especially as the foreign body is often jagged and irregular. In my dealings with such conditions hæmorrhage is often started when the foreign body comes forward and however gently and carefully they are handled, traumatism is a very big factor and has been the chief cause of making me seek other means of extraction.

I use the large electro-magnet in all cases in which the lens is injured. These are the types which, in my experience, have done particularly well by the anterior route. The anterior chamber is opened by a keratome incision, an iridectomy performed after the removal of the foreign body and the traumatic cataract can be dealt with at a later date. If any soft lens matter comes forward, it can be dealt with through the corneal incision. In practically all cases in which the lens has not been injured, I employ the posterior route. I feel somehow this evening that in making this statement I am bringing a hornet's nest about my head. I started practice with a knowledge only of the large Haab's magnet. I treated every case by the anterior route; so that I cannot be guilty of not having tried this method. Maybe others are more successful, have more dexterity, have had more favourable cases to deal with, but I can honestly say if ever I had the misfortune to get a perforating wound of the eye with a foreign body in it and my lens were intact, no Haab's magnet would be employed, provided I could choose my operator.

In my experience the posterior operation done by the method I am going to advocate this evening, gives much better results and has no more complications than the former method. A lot of the success of the operation by the posterior route depends, I think, on the method of entering the globe and the assistance of somebody who understands and realizes the steps of the operation.

In the first place the foreign body should be carefully localized by the Sweet method or by the McKenzie Davidson modification and the site of the incision through the sclera should be made as close as possible to this position. In some cases the foreign body may be situated away back in the posterior pole lying in the retina; if it is above the horizontal plane, I go through the sclera as far back as possible, rotating the eyeball downwards by means of sutures held in the hands of the assistant. If below the horizontal plane, I rotate the globe upwards and enter the sclera below or rotate the eye outwards and enter the globe on the inner and lower surface. Next, a purse string suture is passed through the conjunctiva and Tenon's capsule in a circular manner around the site where the sclera is to be incised by a fine Graefe knife. The conjunctiva in the circumscribed area is then divided with scissors and retracted by means of two anchor stitches which pick up the conjunctiva and get a grip of the episcleral tissues, as in an advancement operation, one anchor stitch on either side of the divided conjunctiva. These two stitches are then used as a means of steadying the globe and at the same time lifting it up so to speak like strings supporting a bag. An incision is then made by a Graefe knife through the sclera parallel with the fibres to prevent undue gaping of the wound. Whilst the assistant carefully holds the anchor stitches, the small electro-magnet is placed just within the lips of the wound and in most cases the foreign body, if magnetizable, will readily attach itself and can be withdrawn. The assistant still keeping the anchor stitches held upwards, the surgeon then ties the purse string suture and not until then are the anchor stitches released and removed.

In this way practically no vitreous is lost and this method in my hands has certainly yielded more satisfactory results than operation by the anterior route.

Another method of treatment I have adopted lately in all cases of perforating wounds of the globe has been to employ a form of protein therapy by giving milk injections. This is practically a routine at the Vienna clinic and is strongly advocated by the ophthalmic surgeons there as a means of helping the resistance of the patient to infection. Much has been written of late regarding protein or non-specific therapy and it is not my intention to-night to weary you with a discussion on this matter. However, I feel sure since using this form of treatment during the past fourteen months, that in traumatic cases many eyes are saved by milk injections which otherwise would have been lost. The milk is boiled for four minutes to sterilize it and amounts from five cubic centimetres to fifteen cubic centimetres are injected deeply into the subcutaneous tissues. Four injections are given in a series, *id est* ten cubic centimetres on the first day, ten cubic centimetres on the second day, none on the third day and ten cubic centimetres on both the fourth and fifth days. The reaction varies with the amounts injected and with the individual.

Non-magnetizable foreign bodies in the globe always present difficult problems. I think very few can be extracted with good results, unless they can be actually seen. The medico-legal aspect is also a worrying one and I would always advise a medical practitioner to have a second opinion when dealing with a case in which there is a non-magnetizable foreign body in the globe. Many eyes tolerate foreign bodies for years and although we examine carefully the eye from time to time for evidence of inflammatory changes and find none, there is always the risk of sympathetic trouble arising or subsequent loss of the eye itself. Although the patient may wish to retain the eye and see no cause for its removal, the responsibility of the case for the ophthalmic surgeon is a heavy one and can well be shared by a colleague. I have seen patients with foreign bodies in the eye under observation for eight or nine years with little or no trouble and fairly good visual acuity, whose eye has ultimately become inflamed and degenerated and has had to be removed. I think most eyes of this kind eventually are lost, although there are exceptions and it is in the hope of such that we are sometimes loathe to enucleate or eviscerate an eye, but rather give the patient the benefit of the doubt and keep the eye under observation provided all inflammatory changes are absent.

I have just attended a court case in Sydney about a patient who got a foreign body in his eye as the result of a gun back-firing at a shooting gallery. The foreign body was localized in the posterior portion of the left globe and not magnetizable. It had penetrated the lens and produced a traumatic cataract and could not be drawn forward by the large electro-magnet. From the history of the case it was surmised that the foreign body was probably a piece of copper from the cartridge case. The eye settled down under treatment and although only perception of light was present, the cosmetic appearance of the eye was quite good. I advised enucleation, but the patient refused. It is now twelve months since the accident and although I realize copper is not well tolerated in the eye and feel that eventually the patient will have trouble, he prefers to take the risk. The eye has been quiet for nine months, far quieter in fact than my feelings have been, but as he has already had similar advice regarding enucleation from other ophthalmic surgeons, I cannot but let the patient take his chance. However, during the past few years our opinions have altered, I think, about the tolerance of eyes for certain foreign bodies and our aim and object in the treatment of these cases should be to give the patient the best chance and at the same time not run an unnecessary risk.

In conclusion I wish to apologize for not having collected records of these cases occurring during the past nine years at Newcastle, but I did not know until a few days ago that I would be able to attend. I had arranged to bring one patient along and he informed me at the last moment that he could not attend. His case is an interesting one. He consulted me some years ago with a history of something hitting him in the eye whilst shoeing a horse. He thought that he had been struck by a piece off the file. The eye was uncomfortable and a little injected for twenty-four hours, but visual acuity was good. He was seen by his own medical practitioner the same day, but nothing was found in the eye. The condition settled down in forty-eight hours, but the patient complained of a "black spot" before the right eye. On the twelfth day after the injury the right eye suddenly became red and painful and the patient was sent down to me by his medical attendant who feared the presence of a perforating wound with a foreign body in the globe. The patient laughed at the suggestion that there was a foreign body in his eye. On examination a small wound of entrance was discovered in the sclerotic just behind the corneo-sclerotic junction on the inner side of the globe. The right visual acuity was "6/12 letters" and on ophthalmoscopic examination a small glistening foreign body was seen on the temporal side of the disc almost in the retina, but apparently in the vitreous. Some hæmorrhage had taken place in the retina between the disc and the macula. X-ray examination confirmed this diagnosis though I hardly think that in this case there was any doubt about it. The lens was not injured and although the foreign body had been present for twelve days, the eye itself showed very little inflammatory change.

Under general anæsthesia I operated upon him by the posterior route and extracted the foreign body which is very small. In this particular case not only did I put the small magnet to the lips of the wound, but actually placed it about six millimetres (a quarter of an inch) within the vitreous, a practice which I do not like to perform. The eye did not react excessively; recovery was perfect and visual acuity "6/6 letters." No fundus trouble has developed and except for a

few fine vitreous opacities the eye is quite well to date. You can examine the foreign body as I have brought it with me.[1]

There are one or two little points I would like to emphasize regarding the treatment and management of these traumatic cases: (i.) Always operate under a general anæsthetic if doing the posterior route operation. (ii.) An objection to using the Haab magnet is that the patient is in the upright position. Many patients suffer a good deal of pain and shock while the foreign body is being brought forward and it is hard to manipulate the patient's head if he has a tendency to collapse. The Mellinger is a better magnet, I think, for the reason that the patient can lie down whilst being operated upon. (iii.) Do not always trust an X-ray report for a correct diagnosis as to the presence or absence of a foreign body and as to its localization, *exempli gratia*: (*a*) A patient with a foreign body in the globe, localized in the orbit with the advice that it should be left alone; (*b*) when a foreign body can be seen with the ophthalmoscope and is not revealed by X-ray examination. I think the clinical signs of perforation and the history of the accident should be our first consideration and when an opinion is formed, it should be backed by X-ray examination and the ophthalmoscopic findings should be compared with the radiographer's report.

GONOCOCCAL VULVO-VAGINITIS IN CHILDREN.

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AND

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MANY medical practitioners hold the opinion that gonococcal vulvo-vaginitis in children usually becomes chronic like gonococcal infection in the adult female.

It is in many instances admittedly a very discouraging, disappointing condition and its treatment in the Out-Patient Department at the Children's Hospital proved very unsatisfactory, but since the Venereal Disease Ward at the hospital has been made available to the Committee of Management by the Government for the treatment of these children as in-patients, the results have improved considerably.

The ward was opened in 1921 and Dr. J. W. Grieve who was senior resident medical officer, instituted a routine treatment which has since been followed with but slight modification.

We have studied the case histories of the first fifty of these patients many of whom we have treated and later seen frequently after apparent cure.

Age.

These children have ranged in age from one month to twelve years. They may be conveniently grouped in conformity with the classification adopted by Macartney and Fraser (*British Journal of Surgery*, April, 1922) into three groups as follows:

Group I., including those under three years of age before free separation of the walls of the vagina;

Group II., including those of three years to eight years during which period the vaginal secretion is alkaline.

Group III., including those over eight years when the vaginal secretion has become acid (see tables).

Source of Infection.

Information as to the source of infection was obtained in only fifteen instances. On two occasions the disease followed criminal assaults by feeble-minded boys who were known to have had gonorrhœa at the time. In seven instances there was a history of leucorrhœa in the mother and in three of these the father had gonorrhœa. In five instances a sister had a similar condition and the children had been sleeping together. In the remaining case the mother was under treatment for gonorrhœa and had a young baby with ophthalmia.

With sixteen of the children, despite the cooperation of the parents, investigation failed to reveal the source of the infection.

In the remaining nineteen cases no information was available either on account of the reticence of the parents or because the children were brought to hospital by officials from institutions or by other persons who had no knowledge of the environment or associations of the patient.

From these facts it may be concluded that as a rule the infection is accidently acquired.

Symptoms.

The absence of subjective symptoms frequently accounts for delay of several weeks before attendance at hospital as parents often overlook the presence of the discharge or fail to attach any importance to it. In a few of these children some frequency of micturition has been associated with scalding, pain and rarely with slight excoriation of the labia. Three of the patients in this series complained first of pain in the lower part of the abdomen, more pronounced on the right side and in one instance radiating to the right loin. In two of these the condition was diagnosed as acute appendicits, but laparotomy revealed a salpingitis with localized peritonitis, apparently a direct spread from the vagina. A baby and a girl aged four years were brought to the hospital on account of gonococcal conjunctivitis and further examination revealed the presence of vulvo-vaginitis.

Complications.

During the course of these investigations the following complications were encountered: Salpingitis three times, cervicitis twice, conjunctivitis twice, arthritis and labial abscess each on one occasion.

Several times during treatment it was noticed that relapses were associated with intercurrent infections such as measles.

[1] Dr. Allen also read the clinical notes concerning several patients from whose eyes he had removed foreign bodies. The report of the discussion will be published in a subsequent issue.

Those patients who showed a recrudescence of the discharge, were very resistant to treatment.

The occurrence of such a complication as arthritis indicates that the infection may become generalized.

Diagnosis.

The diagnosis was determined by microscopical examination of smears stained by Gram's method. In every instance before treatment was instituted the smears showed very numerous polymorpho-nuclear cells and large Gram-negative diplococci which were both intra-cellular and extra-cellular. The smears in a gonococcal infection are characterized by an absence of other organisms. However, in conditions which have become chronic, bacilli and other cocci may also be present. Smears in which pus cells but no organisms are found, must always be regarded with grave suspicion and in such cases further smears should be searched before an opinion is expresesd. Even when the organisms are sparsely distributed in the smear the presence of a leucocyte crowded with large Gram-negative diplococci may usually be found and we regard this typical cell as characteristic of a positive smear. With non-gonococcal vulvo-vaginitis the smears without exception show a heterogeneous mixture of organisms and usually large diphtheroid bacilli predominate. In making the smears it is essential to spread the discharge in an extremely thin layer upon the slide and also to avoid contamination with starch powder.

Treatment.

The four chief objects in the treatment of these cases were as follows:

(i.) The removal of the discharge daily by irrigations. The douche is given through a small rubber nozzle attached by a tube to a can placed at a height of a metre above the patient. For this purpose we have found ordinary ear nozzles satisfactory. Considerable difficulty is experienced at first in restraining the patients during this process, but later they submit more readily to their daily treatment. Various lotions were used from time to time, including normal saline solution, boracic acid lotion and potassium permanganate solutions of various strengths. A comparison of results favoured the use of potassium permanganate in a dilution of 1 in 8,000.

(ii.) The local application of antiseptic solutions. Several different substances were tried: Silver nitrate in solution up to 10%, "Argyrol" up to 25% and soured milk cultures. Of these "Argyrol" in 25% solution was the most efficacious. The applications were made three times weekly after the douche. Dilatation was carried out by means of a medium sized nasal speculum or small throat spatula bent in the form of a Sim's speculum and the vagina and cervix were swabbed directly, the whole field being illuminated by means of a hand light and frontal mirror.

(iii.) The frequent use of dusting powder to keep the vagina dry. Bland, non-irritating, dusting powder were selected such as plain boracic acid, a mixture containing zinc oxide and calomel of each one part with starch three parts or boracic acid, talc and starch in equal proportions and we prefer the last one mentioned. The powder was introduced by means of an ordinary de Vilbiss throat spray which acts as an efficient powder blower and is sterilized by immersion in methylated spirit.

(iv.) The prolongation of rest in bed until the cessation of the discharge. It is presumed that if the patient is kept in bed generalization of the disease and complications due to direct spread are less likely to occur. It was found that when rest in bed was enforced, the discharge ceased quickly, whereas children attending the out-patient department continued to discharge for a much longer period.

Specific treatment by autogenous and stock vaccines was used for several patients, but with no definite beneficial effects.

General medicinal treatment with such substances as sandalwood oil has not been considered necessary.

Progress.

Under treatment as outlined above the quantity of discharge gradually diminished and the smears examined every week showed progressively fewer pus cells and gonococci, until by the end of six or seven weeks the discharge had ceased and gonococci were no longer found in the smears. This period was shorter at times, but in other more obstinate cases a much longer time elapsed before this stage was reached. Age does not appear to be a factor of importance in determining the duration of this period (see tables).

Treatment was continued for at least another month during which the patient remained free from discharge and no gonococci were found on the smears. We should like to emphasize the importance of this phase of the treatment since several of our patients had to be discharged to the out-patient department too soon owing to a demand for beds and in almost every instance there was a relapse with recurrence of the discharge and considerable retardation of the favourable progress.

If at the end of this probationary period there was still no discharge and no organisms were found on the smears, the patient was allowed to leave hospital, the mother or guardian being instructed to use the powder freely in order to keep the vagina absolutely dry and to report at intervals of a fortnight, later extended to one month and three months. At each of these attendances smears were prepared for examination and in this way any recurrence would be detected and another course of treatment instituted. A word of warning is necessary against continued application of powder over a long period as this is liable to cause a chronic irritation and leucorrhœa.

Results.

We presume that all of these children are cured. This presumption is based on continued observation for various periods after cessation of treatment as under: Twelve months or more, six patients; nine months, ten patients; six months, nineteen patients;

TABLE SHOWING AGE GROUPS AND PHASES OF TREATMENT OF PATIENTS WITH GONOCOCCAL VULVO-VAGINITIS.

GROUP I.—UNDER THREE YEARS.

Identification. Initials.	Age. Yrs.	Mths.	Duration of Symptoms Before Treatment.	Duration of Treatment before Cessation of Discharge and Absence of Gonococci.	Duration of Treatment After Apparent Cure.	Period of Observation After Apparent Cure.
O.R.	1	6	3 weeks	7 weeks	4 weeks	n.f.v.[1]
R.G.	1	3	3 weeks	5 weeks	4 weeks	30 months
B.H.	1	10	3 days	7 weeks	4 weeks	n.f.v.
J.D.	2	11	3 weeks	3 weeks	3 weeks	3 months
M.K.	2	7	3 weeks	20 weeks	4 weeks	9 months
J.C.	2	9	10 weeks	13 weeks	2 weeks	5 months
N.C.	1	6	3 weeks	9 weeks	3 weeks	3 months
M.T.	2	1	2 days	3 weeks	12 weeks	6 months
D.M.	2	2	12 weeks	4 weeks	3 weeks	n.f.v.
G.K.	2	8	4 weeks	10 weeks	5 weeks	7 months
P.R.	1	6	1 week	4 weeks	4 weeks	8 months
I.T.	2	1	2 weeks	4 weeks	3 weeks	4 months
J.B.	—	1	2 weeks	18 weeks	8 weeks	5 months
Average	1	11	3 weeks	8 weeks	5 weeks	

GROUP II.—THREE TO EIGHT YEARS.

Identification. Initials.	Age. Yrs.	Mths.	Duration of Symptoms Before Treatment.	Duration of Treatment before Cessation of Discharge and Absence of Gonococci.	Duration of Treatment After Apparent Cure.	Period of Observation After Apparent Cure.
L.C.	5	4	1 week	13 weeks	4 weeks	3 months
G.A.	6	0	1 day	17 weeks	2 weeks	n.f.v.
A.W.	3	6	17 weeks	9 weeks	4 weeks	15 months
I.W.	5	6	1 week	7 weeks	2 weeks	n.f.v.
E.T.	6	0	4 days	10 weeks	3 weeks	n.f.v.
V.T.	4	0	3 weeks	3 weeks	5 weeks	4 months
P.N.	5	0	3 weeks	6 weeks	3 weeks	n.f.v.
A.B.	7	6	10 days	5 weeks	3 weeks	1 month
N.T.	4	3	2 weeks	4 weeks	6 weeks	18 months
E.M.	3	3	2 days	4 weeks	7 weeks	n.f.v.
J.O.	5	0	8 weeks	6 weeks	2 weeks	2 months
W.S.	7	3	2 weeks	5 weeks	9 weeks	9 months
S.H.	4	2	1 week	4 weeks	3 weeks	2 months
V.A.	6	1	2 weeks	4 weeks	4 weeks	4 months
J.C.	6	5	8 weeks	6 weeks	2 weeks	6 months
L.M.	7	0	6 days	4 weeks	2 weeks	7 months
D.M.	6	9	4 weeks	6 weeks	3 weeks	3 months
N.C.	3	3	12 weeks	3 weeks	3 weeks	10 months
D.R.	6	7	4 days	8 weeks	6 weeks	2 months
M.McC.	6	11	2 weeks	8 weeks	1 week	2 months
M.F.	3	1	4 days	47 weeks	6 weeks	2 months
P.D.	5	4	4 weeks	23 weeks	4 weeks	n.f.v.
Average	5	4	4 weeks	9 weeks	3 weeks	

GROUP III.—OVER EIGHT YEARS.

Identification. Initials.	Age. Yrs.	Mths.	Duration of Symptoms Before Treatment.	Duration of Treatment before Cessation of Discharge and Absence of Gonococci.	Duration of Treatment After Apparent Cure.	Period of Observation After Apparent Cure.
E.B.	9	0	1 week	7 months	5 weeks	7 months
M.C.	9	3	2 weeks	2 months	6 weeks	n.f.v.
J.McL.	9	0	3 weeks	5 months	6 weeks	18 months
A.G.	11	11	6 days	2 months	2 weeks	n.f.v.
M.G.	9	2	12 days	1 month	1 week	12 months
E.B.	8	6	10 days	2 months	4 weeks	18 months
Z.A.	10	0	5 days	4 months	2 weeks	2 months
I.P.	9	0	2 days	5 months	26 weeks	5 months
Q.K.	11	9	2 weeks	1 month	2 weeks	6 months
J.B.	9	10	3 weeks	4 months	4 weeks	n.f.v.
A.C.	10	6	4 weeks	3 months	4 weeks	2 months
I.C.	9	6	2 weeks	2 months	5 weeks	2 months
J.C.	11	6	2 weeks	4 months	2 weeks	n.f.v.
E.M.	9	11	2 years	1 month	5 weeks	10 months
E.W.	8	1	6 years	2 months	6 weeks	6 months
Average	9	5	—	3 months	5 weeks	

[1] n.f.v. = No further visits after leaving hospital

three months, twenty-eight patients; two months, thirty-nine patients; no further visits after leaving hospital, eleven patients.

If gonococcal discharge recurred, it was found to be present at the first examination after leaving hospital.

Summary.

Based on our experience of fifty of these cases we advocate the application of the following principles in the management of gonococcal vulvo-vaginitis of children:

(i.) Routine treatment until discharge has ceased and no gonococci are found in the smear: (*a*) Irrigation with potassium permanganate solution, 1 in 8,000 daily; (*b*) swabbing with "Argyrol" in 25% solution three times weekly; (*c*) powdering the vagina freely; (*d*) rest in bed.

(ii.) Persistence in the above routine with the exception of rest in bed for at least four weeks after apparent cure.

(iii.) Period of observation is necessary so that relapse, if it occurs, may be detected.

(iv.) If the treatment as outlined is persevered with, we claim that all cases of gonococcal vulvo-vaginitis in children can be cured.

Acknowledgment.

We are indebted to Dr. Rupert M. Downes, Senior Honorary Surgeon to Out-Patients, who is in charge of the ward in which these patients were treated, for permission to publish this paper.

AUTOGENOUS TRANSPLANTATION OF OVARIES.

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MORE than four years ago a young woman, aged twenty-three years, was sent to me. She was a seamstress by occupation who had suffered for some years with great dysmenorrhœa. The extreme pain lasted for two days and persisted severely enough for her to be incapable of earning her own living for five days before menstruation. The greatest pain was in the left side of the lower portion of her abdomen shooting down to the left leg. Menstruation was always excessive. During the inter-menstrual time she often had to wear diapers because of excessive menstrual discharge. During her attacks of dysmenorrhœa there were excessive dry retching and attacks amounting to semi-unconsciousness. The psychological aspect was such that she desired to end her life. She was greatly emaciated. In consultation I realized the seriousness of her position and suggested a means of attack which she accepted in writing. On February 9, 1920, I operated on her. I opened the abdomen, removed both ovaries, retained the better half of each ovary, making a slit in the peritoneum between the opening of the ampullous end of the tube and the round ligament. I sewed the free edge of the slit portion of the peritoneum to the cut edge of the bisected ovary by continuous catgut suture, the cut surface of ovary resting on the broad ligament. Within three months menstruation was established and since then she has menstruated regularly. For the first nine months menstruation was excessive and lasted eight to nine days. In due course the excess was reduced and menstruation has been quite regular. The pain during the menstrual period has never for a moment returned. After being some time in Western Australia she returned to Victoria and developed tuberculosis in the apex of the right lung. With open-air treatment she returned practically cured. She then married and in the middle of November, 1923, I delivered her of a healthy child. She is again pregnant.

Such a sequence of autogenous transplantation of ovaries is quite remarkable and Dr. W. Mayo, of Rochester, United States of America, cannot recall another such case in America.

The second patient suffered extremely before and during menstruation and I dealt with her in exactly the same way. She did not menstruate for six months and since has been menstruating regularly. At first she had no pain, but suffered from nervous phenomena. Each month menstruation is becoming more normal.

First of all these cases are of interest in that they indicate that there is a purely ovarian dysmenorrhœa as well as a distinct uterine dysmenorrhœa. These are indicative certainly of ovarian pain because the dysmenorrhœa was always very severe till menstruation was established. Moreover, pressure on the ovary produced a pain similar to that which was experienced during the dysmenorrhœa. In presenting the scheme of operation, my idea was that the ovaries should be entirely dissociated from the normal nerve and blood supply and start afresh with I hoped better results, but little did I expect such dramatic results.

Very few patients present themselves for such drastic treatment. We often remove and transplant one painful ovary, but unfortunately results are masked by the presence of a normal ovary.

I may say it is always wise to have a written acceptance of the proposed operation, for if the autogenous grafting does not take, it is just possible that the patient may make an effort to recover damages at law.

Reports of Cases.

SECONDARY TUMOUR OF THE GREATER OMENTUM.

By H. T. ILLINGWORTH, M.B., Ch.M. (Sydney),
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History.

THE patient, H.V.M., *ætatis* fifty-one years, a packer, gave the following personal history: He was born in Ireland and was later a medical student at Dublin University, but gave it up before graduation owing to ill-health. He suffered for years with "chronic bronchitis." His mother died of "old age," his father of cirrhosis of the liver and one brother died of pulmonary tuberculosis. The other family history was not of interest. He had been a fairly heavy drinker and smoker and emigrated to Sydney twelve years ago for the benefit of his health. Since his arrival here he had been greatly improved in health. He worked at various occupations and finally as a packer from which he had to retire nine months ago owing to ill-health and loss of weight. Dr. Ridler, of College Street, Sydney, at length recommended his admission to this hospital owing to the onset of considerable ascites.

Condition of Admission.

Patient was admitted on April 24, 1924, and looked a sallow spare type of man who had lost a good deal of weight. He complained of swollen abdomen, weakness, loss of weight and loss of appetite. On examination it was found that the circulatory system was clear except for a weakness of the second systolic sound at the apex. Respiratory system showed a patch of bronchial breathing with increased vocal resonance and fremitus at

the left base. The nervous and genito-urinary systems were unaffected. The urine had a specific gravity of 1010, no albumin or sugar were detected. The tongue was repeatedly furred, there were several attacks of vomiting reported, having no particular relation to food, but sometimes occurring after taking medicine. The abdomen was protuberant, the liver dulness definitely increased, its lower percussion level reaching to the umbilicus. An indefinite mass was palpated. It extended in the left epigastric region from the costal margin above to the level of the umbilicus below and across the epigastrium to the right rectus muscle at its right border. Its edges could not be definitely defined at all, but a distinct "crepitus" could be made out, reminiscent of that felt in air and gas emphysema, but apparently deep to the abdominal walls. Shifting dulness was present in both flanks. The bowels moved with difficulty. The patient had no inclination for food. On rectal examination some stenosis was noticed, but no mass was palpated. A provisional diagnosis of cirrhosis of the liver was made, with either tuberculous peritonitis or abdominal neoplasm.

Prognosis, Progress and Treatment.

An unfavourable prognosis was made owing to the weak condition of the patient, his great loss of weight and his inability to take sufficient nourishment. Compound powder of jalap and sulphate of magnesia were given on admission, fifteen cubic centimetres of brandy were ordered three times daily and a diuretic mixture prescribed. The patient had a *paracentesis abdominis* performed and approximately thirteen litres of turbid blood-stained fluid were withdrawn without difficulty. The patient felt much easier.

For the next few days the patient showed no response to treatment. He continued to lose weight, kept very little food down, vomited his mixture and had great difficulty in having his bowels moved. On May 16, 1924, he was seen in consultation with two other medical officers and a diagnosis of pancake tumour of the greater omentum made. The patient continued to go down hill in spite of all supporting treatment, such as "Peptonoids," egg-flips *et cetera*. A further paracentesis yielded four and a half litres of blood-stained fluid. The Department of Public Health Laboratory reported the presence of numerous epithelial and blood cells in the fluid. On May 18, 1924, the patient died.

Post Mortem Findings.

The left lung showed a patch of old consolidation. The heart was small and the muscle showed evidence of chronic myocarditis. No valvular lesions were detected. On opening the abdomen the greater omentum was found matted together in the form of a solid tumour extending from the liver above at the right to midway between the *symphisis pubis* and umbilicus below. Adhesions stretched from the *porta hepatis* above and on the right, across the inferior surface of the stomach to the spleen on the left and downwards and towards the right to the caecum and ilium below. The spleen was a little enlarged, the liver quite hard and cirrhotic and the two kidneys small and also definitely cirrhotic. The bladder seemed normal. The caecum, ascending and transverse colons were thickened and had a chain of enlarged lymphatic glands standing out in their mesenteries. The descending colon and sigmoid were infiltrated with hard tissue considered malignant. The upper quarter of the rectum was the seat of a dense mass of solid tissue surrounded with adhesions matted together. Portions of small intestine were semi-gangrenous due to obstruction to their blood supply by enlarged malignant glands.

Pathological Report.

The pathological report confirmed the diagnosis of carcinoma. The rectum was the seat of the primary lesion. The Principal Microbiologist of the Department of Public Health cut the sections and has to be thanked for his expeditious and satisfactory work.

Conclusion.

No. X-ray examination could be done. The patient was too weak to be transferred to Sydney Hospital where all our X-ray work is at present carried out. Abdominal laparotomy was out of the question also owing to the asthenic state of the patient.

I have not had the opportunity of looking up the literature on the subject, but from the comparative rarity with which the condition occurs, as I believe, I have been led to report on the case. I would be glad to have reports of similar cases for the sake of comparison.

I am indebted to the Honorary Surgeon of this hospital for permission to publish this case and for his advice in connexion therewith.

Reviews.

No one who reads the first two volumes of the "General History of the Medical Services" of the war can fail to be impressed with the admirable manner in which the salient features have been extracted from a vast quantity of records.[1] As he showed in his review of the medical services in the Russo-Japanese War, Sir William Macpherson is a master of the art of presenting the gist of a complex situation in concentrated form.

It is stated in the preface that the object of the history is to present in an accessible form the mass of information contained in official documents before they are stored away and so forgotten. It follows, therefore, that the general lessons and history of the development of the medical organization and practice in the late war still remain to be written. The general chapters will be of interest to the general reader, but those dealing with military operations contain too much detail for all but the serious student.

The great value of these volumes lies in the fact that most of the important mistakes are described and the lessons are made clear of what is required for the preparations for any future war.

Volume I. deals with the medical services in the United Kingdom and overseas garrisons as well as the operations in West and South-West Africa and Tsingtau. Excluding the Dominion forces the British Army rose to three and a half millions. For the sick and wounded of the army 640,000 beds were equipped at the time of the armistice, equal to 18% of the army. Over two and a half million patients were brought to the United Kingdom for treatment. The number of the Royal Army Medical Corps personnel was 145,000.

As a beginning the changes in the composition of medical units, the sanitary organization and administration of the medical services as a result of the South African War are described, including that much criticised plan of placing the Director of Medical Services and his subordinates under the Adjutant-General—an arrangement which appears to have become more fixed since the war.

The steps taken to form a reserve to bring the regular Royal Army Medical Corps rapidly up to war strength and the advances made in training methods are described. To these improvements in the organization of the medical services was due what is termed their "exceptional freedom" from criticism during the war. This freedom does not apply to Gallipoli where the deficiency of transport as is now recognized, arose from a lack of cooperation between the executive and medical branches of the staff nor to Mesopotamia.

It is interesting to note that recommendations from the medical services that provision should be made for a definite organization for transport of wounded from field ambulance to casualty clearing station and to make the casualty clearing station reasonably mobile, were not accepted by the Army Council. The soundness of these recommendations was obvious at the very beginning of the war.

The mobilization of the medical services which interests the medical profession in Australia so much, is well described. This was carried out quite smoothly, except in the provision of hospital trains, and this one omission threatened a serious breakdown in the evacuation arrangements. The lesson therefrom is that the whole medical

[1] "History of the Great War Based on Official Documents: Medical Services: General History," in four volumes, by Major-General Sir W. G. Macpherson, K.C.M.G., C.B., LL.D. Edinburgh: His Majesty's Stationery Office; Volume I., 1921. Demy 8vo., pp. xv. + 463, with twenty maps, charts, etc. Price: 22s. net. Volume II.; 1923. Demy 8vo., pp. 520, with illustrations. Price: 22s. net.

organization must be complete at the outset. The valuable help given to the Army Medical Services by voluntary organizations is appreciated, though the failure of the British Red Cross Society to maintain connexion with the army organization in peace is trenchantly criticised. In some instances at first the efforts of these organizations, being premature and impulsive and uncoordinated with each other or the medical services, were a source of embarrassment. At first there was widespread ignorance of the provision of the Geneva Convention that all voluntary aid societies were under military law. To avoid friction the Director-General of Medical Services in France was also appointed Chief Commissioner of Voluntary Aid Organizations.

In the chapter on recruiting the evil results are shown of untrained civil practitioners examining too large a number of recruits in the first rush. Many physically unfit were passed, to be discharged later. The number of examinations to be carried out by one man was soon limited to forty a day. Great difficulty was encountered in obtaining uniform standards. Finally in consequence of criticism the grading of recruits was handed over to a civil organization. The result of this grading was a census of the national health and this largely inspired the organization made after peace to deal with the questions of public health.

Details of recruiting of the Royal Army Medical Corps appear. By January, 1917, the majority of medical practitioners in the United Kingdom were in military service. Though the difficulties in supplying the vast quantities of medical equipment required were great, at no time was there a lack of the essential remedies and appliances. Included in the equipment issued were sufficient bandages to encircle the globe fourteen and a half times, 88,000 miles of gauze, 7,250 tons of cotton wool and twenty-one tons of quinine.

In appendices details are shown of the numbers of sick and wounded arriving in the United Kingdom from the different theatres of war and there are several tables of equipment.

Volume II. is concerned with the western front. It deals with administration and the work of the field, line of communications and base units. Brief accounts are given of the medical provisions of the Allies, Indian Contingent, Labour Corps and women workers. A detailed account is given of the doings of the medical services from their arrival in France to the Battle of Loos in September, 1915, and in the period of trench warfare to July, 1916. Their tactical employment is especially considered.

Only a brief sketch is given of the manner in which regimental medical establishments and ambulances were employed in the field. More attention is devoted to casualty clearing stations.

The consideration of hospitals is condensed into one chapter. It is noted that one-half of the total number of patients were transferred to England and that at the time of the armistice there were 95,000 beds in France.

In the description of the more important battles the military situation is described. Then follows the medical situation and preparations. A brief summary of the actions of the battle then precedes a detailed account of the doings of the medical units. Lists of casualties are included with very useful appreciations of the lessons of each battle.

Numerous clear maps help to make the action of the divisions and medical units clear. An excellent selection of informative graphs and diagrams has been made, some of which make their information more clear than words and figures. Such an one is the diagram illustrating the destination of an average thousand men admitted to a general hospital.

The photographs illustrating various phases of medical units are the only weak feature of the history. Many are far from striking and few illustrate the active work of the units.

The publication of the remaining volumes which deal with the seats of operation of the Australian Imperial Force and have been completed, will be awaited with interest.

A BOOK ON COMPARATIVE PATHOLOGY.

WE have perused Dr. Fox's book on disease in captive wild animals and birds with great pleasure and extreme interest.[1] It is a pioneer in its class and marks a good beginning in what is (except for a few brave sporadic attempts) a new branch of study, namely that of disease in the inhabitants of a zoological menagerie. The Philadelphia Zoological Garden is fortunate in the possession of Dr. Herbert Fox, the writer of this book, as its chief pathologist and it is to be congratulated also in the possession of co-workers of the quality of Dr. E. P. Corson White and Dr. F. D. Weidman who have each contributed valuable chapters on special subjects, the former on the relation of diet to disease and the latter on animal parasites. Dr. C. B. Penrose, the president of the Philadelphia Zoological Society, by whose enlightened policy the work has been fostered and carried on now for over twenty years, contributes a foreword which is itself not the least interesting part of an interesting book. Since November, 1901, systematic autopsies have been made on every animal dying in the Garden. Before that date there was no regular scientific examination, no staff, no recording nor indexing. At that time this state of things was not peculiar to the Philadelphia Garden. It existed in every zoological garden in the world and Dr. Penrose says it exists in most of them today. What these other gardens have missed becomes apparent when what has been accomplished is noted in this book. The number of mammals subjected to autopsy has been 1860 and the number of birds 3505 a total of 5365. In addition there have been some on reptiles, but the number has not been given.

The work was begun in the pursuit of knowledge for its own sake, but it has reacted to the great advantage of the animals. Methods of preventive hygiene have developed by which the incidence of disease has been enormously reduced and much loss avoided. Not only have the animals benefited. The keepers have seen the benefit, their interest has increased and their morale has improved where there had been formerly been many discouragements.

The value of the work, however, is not confined to its bearing on menagerie animals. Nor is it merely of veterinary interest. The medical reader who takes a lively interest in pathology and hygiene, will find in it much food for thought.

Tuberculosis of various types is or was common and Dr. Fox has contributed much information on the incidence of tuberculosis in monkeys, formerly a scourge, but now practically conquered. Control was gained by systematic use of diagnostic injections of tuberculin and by the improvement of hygiene in various ways. Osteomalacia is a very common and destructive disease, as it is other menageries. Paget's *osteitis deformans* is also met with and seems to be very closely related to osteomalacia in its causation. Dr. Corson White's work on the relation of diet to disease promises to make still further improvements in the health of captive animals, especially in relation to bone disease, and it is not without application in regard to domestic animals and man himself.

Dr. Fox speaks in high appreciation of the pathological work carried out at the London Zoological Garden. We may recall that Bland Sutton was doing pathological work in the London Garden as long ago at 1884 and he showed then what a valuable class of material was to be found in such collections.

A little work, but not enough, has been done in Australia. We remember that Campbell and Cleland have published a well-worked out paper of great pathological interest on a disease they described as "cage paralysis" of monkeys. This appeared in 1919, in the *Journal of Comparative Pathology and Therapeutics*. It was founded on material from the Sydney Zoological Garden.

Dr. Fox's book will stimulate us to do more.

[1] "Disease in Captive Wild Animals and Birds: Incidence, Description, Comparison," by Herbert Fox, M.D., with a Foreword by Charles B. Penrose, M.D.; 1923. Philadelphia, London and Chicago: J. P. Lippincott Company; Crown 4to., pp. 665, with 87 plates and 28 tables.

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National Health Insurance.

For some years governments of all political schools have openly or by implication threatened the public in the Commonwealth with the introduction of some form of national health insurance. The matter has been advanced a step by the appointment of a Royal Commission to examine the whole question and to advise the Federal Government if there is or is not need for legislation and what forms of insurance would be most advantageous. The Royal Commission has embarked on a wide expedition and has sought information on many subjects which scarcely seem to be within the scope of its reference. The British Medical Association in Australia has been invited not only to give evidence, but also to suggest a scheme that would be advisable and acceptable to the medical profession. Each of the Branches of the British Medical Association has considered the subject and many meetings have been held at which this subject has been discussed. The Federal Committee has given much attention to every aspect of national health insurance and has now determined to inform the Royal Commission that it will continue to investigate the attending circumstances with a view, if it be possible, to the elaboration of a scheme which would be to the public advantage. In each State a *questionnaire* has been circulated among the members of the Association and information of considerable significance has been collected. From the replies to this *questionnaire* and from the opinions expressed by some speakers at meetings, it would seem that the questions at issue are often ignored or are not fully understood, while the destructive criticism embodied in the unqualified objection to the application of the English plan of national insurance to Australia is not calculated to lead to a satisfactory solution of the problem.

The medical profession should take notice of the fact that the Federal Government has pledged itself to the introduction of some form of national health insurance containing compulsory machinery. The Royal Commission has manifested great reluctance to discard the principle of medical benefit, by which is meant the provision of medical attendance to insured persons as part of the privileges of the insurance. It is claimed by the members of the Commission that a substantial number of persons in the Commonwealth at present does not or cannot obtain medical attendance at all. It is on this contention that the Commission bases its determination to explore every avenue of information and opinion before it formulates its policy. In these circumstances the medical profession should avoid mere destructive criticism and itself formulate a policy, in order that the deplorable event of an unpalatable scheme being thrust upon it while opinions are divided, may be avoided. There would be no excuse for the medical profession if it found itself in the same position as did our English *confrères* in 1913, for the Royal Commission has appealed to the British Medical Association in Australia for assistance and guidance, while Mr. Lloyd George rode rough-shod over the medical profession, scattering dust into the eyes of his opponents in the old country. The medical profession must therefore offer a constructive scheme to the Royal Commission or to the Federal Government and it must also be prepared to take up a firm attitude, should the legislative proposals take a form unacceptable to the profession.

What are the facts as far as they have been ascertained? The opinion is held almost universally that there is no need for the introduction of any of the existing plans of national health insurance. Incidentally the point may be repeated that the English act is not in reality a measure dealing with the health of the community. Dr. Newman Morris and Dr. Cumpston have both demonstrated that none of the provisions which have been put into force, are capable of reducing to a material extent the amount of infective disease. If many people do not obtain medical attendance, the causes must be either that they reside in some inaccessible portion of the Commonwealth where there are no medical practitioners within call or that they are so improvident that they do not seek what is avail-

able. There is no doubt that the wage earner has in the friendly societies, the hospitals, the hundred and one benevolent and quasi-benevolent institutions and societies ample provision for some form of medical attendance. The friendly society lodge practice in Australia is probably the best general practitioners' medical service in the world. That it is not and cannot be ideal will be admitted by all, for the contract does not admit of a sufficient amount of individual care and of all the advisable auxiliary aids to accurate diagnosis and treatment that are demanded by modern medicine. The less well-to-do and the poor obtain in hospitals all the team work that is needed for the thorough elucidation of pathological processes. It may therefore be concluded that the refusal of the medical profession to entertain the mere shifting of contract practice from its present position with the friendly societies to another fathered by the Government is justified and wise. It must be remembered that the contract with the friendly societies covers only the wage-earning portion of the population and their dependants. The unemployed and the unemployable stand outside this arrangement and also stand outside the arrangements included in all known forms of so-called national health insurance. If the Government were to ask the medical profession to extend its contracts to include these classes of individuals, two considerations would have to be mentioned. In the first place the candidate is admitted as a lodge member only if he is well and healthy. If persons with physical disabilities at the time of joining are to be included among those entitled to medical benefit, the rate of remuneration must be very substantially increased. We would suggest that in view of the admitted limitations of the friendly society lodge system it would be inadvisable and not in the public interest to extend it. Some other provision could be discovered whereby the Government could secure at its own cost adequate medical attendance for persons unable to contribute to any insurance scheme themselves and to gain admission to the friendly societies on account of existing illnesses or incapacitating defect. The Branches have been asked to evolve a scheme and to submit to the Federal Committee at its next meeting proposals to serve as a basis for some practical form of insurance. If it be recognized that adequate medical and surgical attendance in a proper interpretation of these terms is not available to a large number of Australian citizens, it becomes the duty of the medical profession to lend its aid in creating provisions under conditions and on terms that shall not prove a burden to the community as a whole.

While this aspect of the health insurance question is urgent on account of the attitude adopted by the Royal Commission and possibly in view of the facts, there is another aspect which is of far greater importance and far greater urgency. This is the provision of improved facilities for the prevention of disease. There is much to be said concerning this matter. Some of it has been admirably presented in the report by Drs. Hone and Newland, a report that is being amended in some minor respects in deference with the expressed wishes of some of the Branches of the Association. It has also been explained in a masterly manner by the Director-General of Health in his evidence before the Royal Commission. It will be necessary to return more than once within the next few months to this subject in these columns, for any well-devised scheme of national insurance which is cast in a manner calculated to reduce the amount and severity of illness among the people, must command universal support.

Current Comment.

TUBERCULOSIS OF THE LARYNX.

THE monographs or special reports published by the Medical Research Council of the Privy Council as a rule are authoritative documents compiled by practitioners of eminence in their special fields of activity. It is true that in a few instances the Council has not endorsed the opinions expressed by the authors and have made a definite announcement to this effect in a preface. There is no preface by the Council attached to a report by Sir St. Clair Thomson on tuberculosis of the larynx.[1] It is reasonable to assume that this signifies that the Council which is composed largely of men with great reputations, is prepared to accept the doctrines enunciated by this author. The greater part of the evidence on which Sir St. Clair Thomson bases his views, is quite reliable, although it is not

[1] "Tuberculosis of the Larynx. Ten Years' Experience in a Sanatorium," by Sir St. Clair Thomson, Special Report Series, No. 83, Medical Research Council of the Privy Council; 1924.

always wise to accept statistics in support of preconceived hypotheses. Unfortunately the author's story is so indifferently told and his use of words is so careless and inaccurate, that the critical reader would be inclined to question the reliability of some of the findings were it not for the fact that he is well known as a competent observer. But a few years ago the prognosis of tuberculosis of the larynx was held to be very bad indeed. Once the physician recognized that the larynx was involved in the tuberculous process, the doom of the patient was sealed. This was not a mere indication of pessimism on the part of the profession during the latter part of last century. It was the outcome of careful observation by the most careful observers and the most skilful clinicians. But the same thing may be said of pulmonary tuberculosis. There was a time within the recollection of many medical practitioners alive at the present day when few persons known to be suffering from pulmonary tuberculosis recovered. The history of sanatorium treatment illustrates the almost if not quite hopeless outlook of the consumptive fifty years ago. Today we know that there is a substantial recovery rate, even if it is not as high as some of the optimistic physicians who use the sanatorium and tuberculin, would have us believe.

During the course of ten years Sir St. Clair Thomson examined the larynges of no less than 2,541 patients at the Midhurst Sanatorium and discovered that the tuberculous process had involved this organ in four hundred and seventy-seven or 18.77% of the total number. The treatment instituted consisted in the complete abstention from the use of the voice in sixty-seven persons, in the avoidance of ordinary speaking and the use of the whisper voice in three hundred and thirty-six persons and in the application of the galvano-cautery in the remaining seventy-four patients. Silence as a method of treatment is recommended for all recent and acute infections of the larynx, especially when the lesions are limited to part or the whole of the vocal cord or to the inter-arytenoid region. Of the sixty-seven persons so treated twenty-three were "cured." It appears, however, that ten of these "cured" patients died after periods varying between eighteen months and seven years and ten months. In eight the cause of death was unknown. In only one of the ten was it certain that the larynx had remained healed. It is unjustifiable to employ the term "cure" in this connexion. Unless it can be shown histologically and by animal experiment that the larynx is free from tubercle bacilli, all that it the clinician can do be sure of is that the obvious lesion is healed. But it is certainly remarkable that in this group of selected patients clinical healing occurred in 34.3%. Of the three hundred and thirty-six patients whose treatment consisted in the reduction of the voice to whispering, fifty were lucky enough to experience healing of their laryngeal lesions. Twenty-two of them died. This form of treatment seems to be advisable when the much more trying complete silence is not indicated and when the lesions are not held to be suitable for the galvano-cautery treatment. The last method of treatment is reserved for patients whose lesions do not respond to silence or whispers, provided that the general condition is favourable. It is most promising when the lesions are limited to the vocal process, the inter-arytenoid region or the vocal cords. Of the seventy-four persons for whom it was employed, healing took place in forty-six. Of these sixteen died subsequently. It thus appears that of the total four hundred and seventy-seven patients with tuberculosis of the larynx, the local lesions were healed in one hundred and nineteen or almost 25%, while seventy-one or 14.88% were alive and free from obvious lesions at the end of the ten year period. It may be necessary to revise these figures at a later date, since the ten years ended in June, 1921, and the condition of the patient was ascertained in 1922. There would consequently be many in whom the healing was of recent date.

Sir St. Clair Thomson produces a mass of figures to support his contention that laryngeal complications of pulmonary tuberculosis have become less frequent since the introduction of sanatorium treatment. This may be accepted as established in connexion with patients treated at sanatoria. Whether it will be found to obtain in regard to the general population remains to be seen. The complication is uncommon among those with early tuberculous infections of the lungs and very common among patients in the third stage of the disease. The complication is as frequent in women as in men. This discovery is surprising, for all previous figures indicated a greater incidence among males. The lesions are situated as a rule in the posterior segment of the glottis. This fact seems to be of importance in differential diagnosis, since Sir St. Clair Thomson has found that cancer usually attacks the middle or anterior third of the cord and that syphilis may attack any part of the larynx.

The prognosis of tuberculosis is materially affected by an involvement of the larynx. It is found that under the conditions of the author's observations 62.5% of the patients treated at the Midhurst Sanatorium during the ten years from July 1, 1911, to June 30, 1921, for pulmonary tuberculosis without laryngeal disease were alive in 1922; only 29.4% of those with laryngeal disease had survived. It is regrettable that in the former group approximately 15% of the patients had to be excluded from the reckoning because no trace of them could be discovered. The same applies to about 5% of the second group.

The report contains a great deal of further information. Much of it deserves careful study, since the diagnosis, understanding and treatment of this complication of tuberculosis are obviously undergoing a drastic revision. It is probable that with earlier diagnosis of certain infection, with careful and expert control of every part of the body, including the larynx, and with the application of general rather than local treatment, the early spread of infection may be arrested more frequently than it is at present. It is essential to regard tuberculosis as a general infection and to avoid the common error of thinking of it as a disease of the lungs or the larynx.

Abstracts from Current Medical Literature.

PÆDIATRICS.

Infantile Vomiting.

GUSTAV LINDBERG (*American Journal of Diseases of Children*, March, 1924) describes a case of habitual vomiting in an infant, due to an atonic condition of the stomach. The patient was a full-term female infant whose birth weight was 3,400 grammes. Vomiting began two days after birth. It occurred after the meal or after a short interval and was not projectile. At the beginning of the second week the weight dropped rapidly and there was loss of appetite. The vomiting at this time was voluminous and projectile. The author first saw the infant when it was two weeks old. The upper quadrant of the abdomen was slightly distended. Distinct peristalsis of the stomach was seen, with waves starting far to the left and progressing up to the middle line but not beyond this. Through a fine catheter one hundred cubic centimetres of breast milk mixed with five grammes of "contrast powder" were introduced into the stomach. This was done with the patient lying down and the behaviour of the stomach was examined every five minutes under fluoroscope. None of the stomach contents passed through the pylorus as long as the infant remained in the horizontal position. Immediately the infant was placed in the vertical position the stomach contents started to pass over into duodenum. Even in this position there was complete absence of tonic contraction. The stomach, however, emptied rapidly. Since it had been shown by this examination that no pyloric nor other obstruction prevented the emptying of the stomach the baby was fixed almost upright in bed by the aid of pillows. The vomiting ceased at once and a rapid increase in weight took place. This improvement continued steadily. The appetite increased at once and no vomiting took place unless the infant was lowered to a horizontal position. After three weeks the baby could lie down without vomiting and later development was normal. The author explains the condition described by referring to what is known as the motor functions of the stomach. The walls of the stomach in the adult contract round its contents. Stiller calls this the peristolic function. The second function is that of peristalsis, consisting of waves of contraction passing from the cardiac end of the stomach to the pylorus. The emptying of the stomach takes place through the joint peristolic and peristaltic actions. Leven and Barrett have shown that the peristaltic function is not developed in the infant. Peristalsis occurs as in the adult and is usually sufficient to empty the stomach. Flesch-Peteri has observed that the absence of peristolic function depends on the nature of the contents. If milk is replaced by food of more solid consistency, a powerful tonic contraction occurs even in the infant. The author concludes that the inability of the stomach to empty itself in a normal way when the infant was in a horizontal position was due to the absence of a proper peristolic action. He adds that not only vomiting, but lack of appetite in the newly-born may be due to this atonic condition.

Infantile Convulsions.

JOHN THOMSON (*The British Journal of Diseases of Children*, October—December, 1923) describes peculiar fatal convulsions in four children whose father suffered from lead-poisoning. The author saw only one of the children. He came under observation at the age of ten months. He had been seized with fits of a serious and unusual nature. The attacks had begun when he was ten weeks old. He was born after a normal labour, was breast fed and had thriven normally in every respect. The fits always came on during sleep and he usually had one or two each night. He became restless without waking, shook his head from side to side and yawned. Then difficulty of respiration began with without any crowing inspirations. He lost consciousness and his mother could no longer hear his breathing. The whole body was stiffened, the hands were not clenched and there were no clonic movements. After a minute or two the breathing became quick and easy and consciousness returned. The child was bright and attractive, well advanced in development for his age. He had no signs of rickets and nothing abnormal was found on physical examination. The fits persisted in spite of treatment, becoming more severe as he got older. The character of the attacks remained the same. He died at the age of eighteen months in a severe fit. He was the sixth child. The first two children had always been healthy. The third, fourth, and fifth children had had fits precisely similar in character to those which this baby had. The infants had died at thirteen, eight, and nine months respectively. The father had been a painter for twenty years. He worked in a small dirty shop where they handled a great deal of white lead. Two years after his second (healthy) child was born he began to show signs of lead-poisoning. He died eleven years later of nephritis and uræmia. All the children born after the father's lead-poisoning began were seriously affected, although the mother remained healthy. This child remained until near the end in excellent mental and bodily health. These convulsions were different in their phenomena from ordinary infantile convulsions, affecting the respiratory functions specially and yet not resembling those in laryngismus or *status lymphaticus*.

Acidity of Gastric Contents.

W. MCKIM MARRIOTT AND L. T. DAVIDSON (*American Journal of Diseases of Children*, December, 1923) discuss the acidity of the gastric contents of infants under normal and pathological conditions. As the action of hydrochloric acid in the process of digestion is largely, if not entirely, due to the number of free hydrogen ions present, the authors determined the hydrogen ion concentration at the height of digestion following a regular feeding. The gastric contents were removed from infants at the height of digestion and the hydrogen ion concentration was determined by means of the simple dialysis-indicator method. The gastric contents of forty-one normal infants fed on breast milk were studied. In over two-thirds of these the pH fell between 3 and 4. The average for the whole series was 3.75. A group of sixteen abnormal infants fed on breast milk was studied. These infants were suffering from acute and chronic infections. The pH of the gastric contents of most of these infants varied between 4.4 and 4.8. All had pH above 4. The average was 4.74. Thus the actual concentration of hydrogen ions in the stomach of these infants at the height of digestion averaged only one-tenth as much as that of normal infants receiving the same food. Owing to the fact that cow's milk contains a large amount of "buffer" material, when an acid is added a portion of the hydrogen of the acid is converted into a non-ionized form and the true acidity of the solution is greatly reduced. Human milk contains a smaller amount of "buffer" material. On feeding undiluted cow's milk to a group of normal infants it was found that the average pH at the height of digestion was 5.3. In the case of abnormal infants fed on cow's milk, the average pH at the height of digestion was 5.35. When lactic acid milk containing from 0.5% to 0.7% of lactic acid was used as a food for normal infants the average pH was found to be 3.71 as compared with 3.75 in the case of breast milk. In abnormal infants fed with lactic acid milk the average pH was 4.1. The authors proceed to discuss the significance of the gastric acidity. A certain hydrogen ion concentration is necessary in order that the peptic digestion of protein may occur. It has been found that peptic digestion begins at pH 4 and is optimum at pH 2. From the results obtained the authors state that it appears that some peptic digestion was possible in over two-thirds of the normal breast-fed infants and in a moderate number of the infants fed on lactic acid milk. It may be argued that all the protein could escape peptic digestion without harm to the infant. On the other hand it has been shown that peptones resulting from peptic digestion are capable of stimulating the flow of pancreatic juice and bile and even the small amount of peptone

formed might well act in this way. An important function of the gastric juice is its antiseptic action. It has been shown that at pH 5 definite inhibition of the growth of members of the colon, dysentery and typhoid groups takes place. At pH 4 complete inhibition or death of these organisms occurs. Hence a sufficient degree of acidity of the gastric contents, such as occurs in normal breast-fed babies and in those fed on lactic acid milk, greatly decreases the chance of infection of the upper portion of the intestine. Hence the importance in selecting a food for the infant, of taking into account its "buffer" or acid binding qualities.

ORTHOPÆDIC SURGERY.

Recurrent Dislocation of the Shoulder.

W. RUSSELL MACAUSLAND (*Surgery, Gynecology and Obstetrics*, June, 1924) discusses recurrent dislocation of the shoulder. The pathology varies widely in different individuals. In some instances there is actual avulsion of the capsule from its attachment, in most cases it is raggedly torn and stretched to such an extent that an actual pouch is formed. Abnormalities of the bones have been observed. Chief among these are a defect in the humeral head, such as a wedge-shaped notch on its posterior side and a wearing away of the lower margin of the glenoid cavity. The muscles supporting the head are found torn and atrophied. Treatment may be conservative or operative. When displacement has recurred frequently, conservative treatment is of no avail. The author describes the type of operation undertaken by him. An incision is made parallel with the axillary vessels and posterior to the direction of the arm when held at an angle of ninety degrees from the side. The subscapular muscle is exposed. It may be retracted or divided in the direction of its fibres. A full exposure of the capsule should be obtained. A curved incision is made parallel with the glenoid and midway between it and the middle of the humeral head. The head is carefully examined and replaced. The capsule is well overlapped and sutures placed but not tied until the arm is brought down to an angle of forty-five degrees with the side of the body. Chromasized catgut is used and the subscapular muscle is returned to its normal position. The arm is retained at the side for about six weeks. The arm should be protected from forced abduction for a period of three to four months. The author gives the clinical notes of six patients treated by this method. The result in every instance was entirely successful and extended over varying periods up to twelve years. The author concludes with an historical survey of the different surgical methods used in the treatment of this condition. These include capsulorrhaphy without arthrotomy, capsulorrhaphy after excision of part of the capsule and capsulorrhaphy together with the treatment of other lesions in order to give additional support to the joints.

Transplantation of Callus.

G. H. KLINKERFUSS (*Surgery, Gynecology and Obstetrics*, May, 1924) has carried out a series of experiments in order to determine the fate of callus when transplanted into costal cartilage. Rabbits were employed. Saw cuts were made into the ulna under aseptic precautions, but the periosteum was not stripped off the bone. Callus appeared after seven days. Portions of the callus from seven to twenty-one days after the trauma were transplanted on costal cartilages after the perichondrium had been scraped off to make a bed. Simultaneously transplants of solid bone were made into the costal cartilages of the same animals to serve as controls. From a microscopical study of the callus it was found that after seven days the tissue had the appearance of vascular fibrous tissue with large round cells containing a dark-stained round nucleus. After eleven days the whole callus consisted of loosely arranged cells resembling embryonic cartilage. Around the capillaries the cells were densely packed. There was evidence of bone trabeculation. After fourteen days there were signs of calcification. There were trabeculæ of somewhat concentric circles of proliferating bone with capillaries surrounded by osteogenic cells. Large numbers of osteoblasts were seen. After twenty-one days the specimens had the characters of cancellous bone, except that the spaces containing the capillaries still included actively growing osteoblasts. It was found that when callus was implanted into a prepared bed in costal cartilages it did not die, but that new bone was rapidly formed. On the other hand the control solid bone grafts died, were absorbed and were eventually replaced by new bone tissue resulting from the proliferation of osteoblasts, of the periosteum and of Haversian canals. The difference between the results of the callus grafts and the bone grafts, however, persisted only for a period of between sixty and ninety days. Ultimately the same form of new bone resulted in each case. Moreover, the quiescent period was reached at about the same time whether callus or solid bone was used as the grafting material.

The Fate of Boiled Beef Bone Pegs.

CHARLES DAVISON AND FREDERICK CHRISTOPHER have sought to determine the fate of boiled beef bone pegs in fractures of long bones in dogs (*Surgery, Gynecology and Obstetrics*, April, 1924). Rigid asepsis was practised and all the operations were performed in hospital operation theatres. The arm bone of dogs was sawn through at right angles to its axis and suitable beef bone pegs were used to obtain rigid alignment. It was found to be advisable to employ rectangular pegs to fit into the round medullary cavity in order to restrict the points of contact to four points. In this way the intervening spaces of the endosteum were not subjected to increased pressure. Numerous experiments were carried out, but in no case did the peg suffice to yield a satisfactory union of the fragments in proper position. Infection occured in many instances. It was found that the live bone remained in intimate and firm contact with the dead bone of the peg. The dead bone was invaded and replaced by live bone. The invasion was studied. The pegs gradually melted away and the new bone formation took place both by invasion and replacement and by deposition around the new blood vessels which penetrated the absorbing dead bone. The new bone is gradually absorbed. It was further found that no new bone formation took place in situations in which the peg was not in contact with the endosteum. Thus the callus did not bridge the gap between the fragments of the fractured bone. The failure in the series was attributed to infection, failure of mechanical reduction, lack of continuous immobilization and loosening of the repair by absorption of the peg and surrounding live bone. At times the peg disintegrated from absorption at the time of fracture. The authors found that a mechanically perfect repair would yield a good result as long as the peg remained strong enough to keep the fragments in apposition and alignment.

Scoliosis Treated by the Fusion Operation.

RUSSELL A. HIBBS (*Journal of Bone and Joint Surgery*, January, 1924) issues a report of fifty-nine cases of scoliosis treated by the fusion operation. The operative technique is described fully with illustrations. No post-operative support is applied, but the patient is placed on a bed without springs. At the end of two weeks when the wound is healed, a plaster of Paris jacket is applied with the spine under the influence of traction. This is worn for six weeks and the patient in confined to bed. After this a removable jacket is worn for six or twelve months. The occurrence of shock was rather rare and never serious, but two patients died, one from lobar pneumonia four days after the operation and the other from acidosis the day following the operation. One wound only was infected. As a rule the greatest amount of correction was obtained in the younger patients and in those in whom deformity had existed for the shorter periods of time. In estimating the end results 48.8% were excellent and by this is meant that carriage and posture were practically normal. The poor results were 6.6% and were due to extreme paralysis of the entire musculature with severe thoracic deformity. In a number of severe cases natural fusing was found at the time of operation.

British Medical Association News.

SCIENTIFIC.

A MEETING OF THE NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION was held at the B.M.A. Building, Elizabeth Street, Sydney, on May 29, 1924, DR. ANDREW DAVIDSON, the President, in the chair.

Gonorrhœal Tonsillitis.

DR. P. FIASCHI, O.B.E., read a paper entitled "Gonorrhœal Infection of the Tonsils, Associated with Urethral Gonorrhœa, Both Acquired from the Same Source." A discussion took place.

Chronic Urethritis.

DR. L. E. ELLIS read a paper entitled "Chronic Urethritis" (see page 105).

DR. N. M. GIBSON, O.B.E., said that he had been impressed with the way in which Dr. Ellis had put the whole question before them. Infiltration of the posterior portion of the urethra was more or less rare when complications in the anterior portion were considered. He had seen stricture on three occasions between the neck of the bladder and the *veru montanum* and on four occasions between the *veru montanum* and the membranous urethra, Polypoid formation had frequently been found in the past. He had not realized this until he had had the opportunity of carrying out many urethroscopic examinations while on active service. His experience while attached to military hospitals had been that polypoid formations had almost disappeared on the introduction of treatment by massage, dilatation and so forth. With the present day treatment of routine dilatation and attention to the *vesiculæ seminales* and the prostate the occurrence of polypoid formation was rare. Dr. Gibson thought that posterior urethroscopy was mainly a diagnostic measure. It was not necessary to use this method of examination unless there were indications of infection of the posterior portion of the urethra.

DR. R. GORDON CRAIG referred to an interesting point in the mechanical construction of endoscopes. If the tube of the endoscope had a straight end, it was necessary to use a guard while passing the instrument. When the guard was withdrawn, the endoscope could be withdrawn gradually and examinations could be carried out while this was being done. The instrument could not, however, be pushed back into the canal without the infliction of trauma on the mucosa. This trauma was caused by the bulging inwards of the mucous membrane. Chevalier Jackson had overcome this difficulty by constructing an endoscope the edge of which was turned slightly inwards on one side. The end of the tube was not cut at a right angle but was bevelled and surrounded by a thickened ring of metal. Dr. Craig said that a urethroscope had been constructed on this principle and he laid stress on the fact that endoscopy was the same in any part of the body.

DR. J. ADAM DICK, C.M.G., pointed out that chronic urethritis was of common occurrence. The patient became alarmed and the question that had to be decided was whether or not gonorrhœa was still present. Again it was necessary to go back to the bacteriologist. Sometimes he could help and sometimes he could not do so.

DR. J. S. PURDY, D.S.O., referred to what he termed the psychological effect of urethroscopy on the neurasthenia of patients suffering from chronic urethritis. He also referred to some experimental work he had carried out at Cleopatra, Alexandria, Egypt, whilst regimental medical officer to the First Australian Divisional Ammunition Column in 1915. He had used injections of hypertonic supersaturated salt solution, sea water, in cases of chronic urethritis. Some benefit had been apparent although he could not affirm that any definite cures had been effected, as after a few weeks he had been transferred to Cairo to take up a sanitary appointment.

DR. ELLIS in reply said that he wished to thank those present for the way in which they had received his paper. He re-affirmed the frequency of polypoid conditions in chronic urethritis and denied the sufficiency of removal of cause to insure a cure when the condition amounted to established and self-supporting anatomical lesions. He referred to the results obtained by Gautier, of Paris, in the treatment of polypoid and similar conditions of the urethra by the high frequency current. This method of treatment would cure the disease when other methods of treatment failed to do so. In regard to genito-urinary neurasthenia, he contended that the removal of the basic lesion would result in a cure; it was often sufficient if the filaments could be eradicated from the urine. He concluded by laying stress on his view that chronic urethritis was a disease which was quite distinct from gonorrhœa.

MEDICO-POLITICAL.

MEETING OF THE FEDERAL COMMITTEE.

A MEETING of the Federal Committee of the British Medical Association in Australia was held at the B.M.A. Building, 30 to 34, Elizabeth Street, Sydney, SIR GEORGE A. SYME, K.B.E., in the chair.

Representatives.

The following representatives of the Branches attended the meeting:

New South Wales Branch: DR. R. H. TODD, DR. J. ADAM DICK, C.M.G.
Victorian Branch: SIR GEORGE A. SYME, K.B.E., DR. R. H. FETHERSTON.
Queensland Branch: DR. W. N. ROBERTSON, C.B.E., DR. J. LOCKHART GIBSON.
South Australian Branch: DR. H. S. NEWLAND, C.B.E., D.S.O., DR. BRONTE SMEATON.

Apologies for non-attendance were received from DR. F. A. HADLEY and DR. J. P. SEED, the representatives of the Western Australian Branch.

Congratulation.

DR. W. N. ROBERTSON moved that the Federal Committee convey their heartiest congratulations to Sir George A. Syme on the honour which His Majesty the King had been pleased to confer on him. He assured Sir George that the medical profession not only in Victoria, but also in all the other States had rejoiced greatly on learning of the event. They had been extremely pleased because they all felt that no one had ever deserved the honour more than their Chairman. He was "a very perfect, gentle knight, who loved chivalry, truth and honour."

The motion was carried with acclamation.

SIR GEORGE SYME thanked his colleagues for their kind and enthusiastic expressions of good will and congratulations. Nothing had gratified him more than the way in which the profession had received the news.

Medical Officers' Relief Fund.

A letter from Dr. W. H. Crago on behalf of the Trustees of the Medical Officers' Relief Fund was read together with an audited statement of accounts. It was noted that on June 30, 1924, the fund amounted to £11,610 2s. 7d., part of which was invested in Government stock and part was on loan to beneficiaries. The grants made during the year to widows of medical men had been taken from the interest of the invested moneys. The fund had increased in amount to the extent of £289 during the twelve months.

Incorporation of Branches.

Correspondence was read in which the approval of the Central Council of the British Medical Association to the model memorandum and articles of association submitted by the Federal Committee, was announced.

Australasian Medical Congress (British Medical Association).

Draft suggestions for the organization of a session of Congress were read and discussed. The object of this document was to guide the general and executive com-

mittees of any session in regard to the organization and general arrangements and to insure uniformity in the successive sessions. The document was amended and adopted in its amended form.

The consideration of some suggested amendments to the Regulations of Congress in regard to meetings of Sections was postponed.

Next Session.

The Committee considered two invitations to hold the second Session of the Congress within the area of the inviting Branch. The first was from the New South Wales Branch and the second was from the New Zealand Branch. Letters were read from the Council of the New Zealand Branch and from members of the Otago Division urging the claim and asking the Federal Committee to give favourable consideration to their proposal that the second session be held in Dunedin in 1926. While it was recognized that the New South Wales Branch had a strong claim, there were several reasons to induce the Committee to accept the New Zealand Branch's invitation. The representatives of the New South Wales Branch intimated that, while their Branch was prepared and anxious to hold the second session in Sydney, they would be quite satisfied to leave the matter in the hands of the Federal Committee.

After some discussion it was resolved that the invitation of the New Zealand Branch be accepted and that the Chairman and Honorary Secretary should offer their services to assist the New Zealand Branch in any way possible. The Committee recommended that the second session of Congress at Dunedin should be held if possible in the second week of February to meet the convenience of members in the Commonwealth.

National Insurance.

The Royal Commission on National Insurance had requested the Federal Committee to draft the principles of a constructive scheme of national insurance to include full medical and institutional benefits and for preventive medicine. The Secretary of the Royal Commission had intimated that evidence would be taken in Sydney on July 21 and the Federal Committee had been asked whether it was desirous of giving evidence before the Commission at that date.

The Committee had before them the evidence given by Sir George Syme, that given by Dr. J. H. L. Cumpston, the Director-General of Health, and that given by other medical witnesses. A *questionnaire* had been submitted to the members of the medical profession through the Branches at the request of the Federal Committee on the subject of national insurance. Replies had been received from a large number of practitioners and these replies had been collated by the Honorary Secretaries of the Branches and by the Honorary Secretary of the Federal Committee. In addition meetings of Branches had been held and of groups of members in their several localities and the views of many practitioners had been ascertained at these meetings. The great majority of those replying had expressed the view that they were opposed to a scheme of national insurance with medical benefits for Australia on the lines of the *National Insurance (Health) Acts*, 1911 and 1913, of Great Britain. The majority was not in favour of any known scheme of national insurance being adopted. While many reasons were assigned to explain the objections to compulsory insurance schemes including medical benefit as applied to Australia, the one most frequently quoted was that the existing voluntary agencies for the provision of medical attendance sufficed for the community. These included friendly society lodge practice, hospitals, homes and other institutions, benevolent societies, dispensaries and clinics and so forth, the number of persons unable to obtain medical attendance being negligible. Unanimity was absent from the replies concerning the rate of remuneration that would be required, if national insurance were introduced into Australia. The prevalent view was that there should be adequate representation of the medical profession on the administering or controlling bodies and that the medical benefits should not be administered by the friendly societies.

A long discussion took place and it was resolved:

That the Federal Committee reply to the Royal Commission on National Insurance to the following effect:

(i.) The Federal Committee having given grave consideration to the difficult problems involved, finds that the medical profession is generally opposed to medical benefit being included in compulsory national insurance.

(ii.) The Committee does not see its way at present to submit a constructive scheme for compulsory national individual health insurance, but is continuing its investigations of the possibility of formulating proposals for this purpose.

(iii.) The Committee is of opinion that national measures should be instituted which would include (*a*) the provision of adequate ante-natal, midwifery and post-natal treatment, (*b*) laboratories throughout the country for investigation and pathological work, (*c*) treatment of tuberculosis, of venereal disease and of malignant disease and (*d*) institutional treatment on a contributory basis for the class of the community who cannot afford to go into private hospitals and (*e*) the association of medical practitioners with the administrative departments in relation to preventive medicine.

It was further resolved that certain proposals should be submitted to the Branches for consideration as a basis for a constructive scheme of compulsory national individual health insurance.

Medical Attendance on Widows and Orphans of Soldiers Whose Death is Due to War Service and to Widowed Mothers of such Deceased Unmarried Soldiers.

Correspondence was read with the Repatriation Department relative to the arrangements for the provision of medical benefit through the friendly societies at the rates and on the conditions obtaining in each district to the widows and orphans of soldiers whose death was due to war service and to the widowed mothers of such deceased unmarried soldiers. The Department had supplied lists of persons entitled to these benefits. It was pointed out that in many instances advantage of the arrangements would not be taken. The correspondence and the lists were received.

Cooperation of the Medical Profession with the Commonwealth Department of Health.

The Committee considered the replies that had been received from the Branches in regard to the report drawn up by Dr. F. S. Hone and Dr. H. S. Newland, acting as a sub-committee of the Federal Committee on the cooperation of the medical profession with the Commonwealth Department of Health (see THE MEDICAL JOURNAL OF AUSTRALIA, March 22, 1924, page 296). Certain amendments were suggested by the Branches and it was therefore resolved that the report be referred back to the sub-committee for the incorporation of the suggested alterations.

Treatment of Naval Personnel.

The Navy Office forwarded earlier in the year a request that arrangements might be made with a view to the fixing of a scale of fees which the Association considered adequate for attendance on Naval ratings by civilian medical practitioners. This matter had been referred to each of the Branches for consideration. The position in Great Britain was explained as was the attitude taken up by the Central Council of the British Medical Association in this connexion. After some further discussion it was resolved:

That the fees charged for attendance on Naval personnel should be the same as those paid for medical attendance in the several localities and that the Director of Naval Medical Services be advised that these fees would not include the cost of the necessary medicines.

Expulsion of Members of the Association.

A letter was read from the Medical Secretary of the British Medical Association informing the Federal Committee that the Federal Committee of South Africa had desired the alteration of the Articles of Association to transfer the powers of expulsion of members of the British Medical Association in South Africa from the Branches to the Federal Committee. Dr. Cox inquired whether the Federal Committee would wish this alteration to be applicable to the Branches in Australia. After some deliberation it was resolved that a reply be sent to the effect that the Federal Committee did not think that the proposal would be practicable in Australia at present.

Medical Insurance Agency.

At the meeting of the Federal Committee on February 26, 1924, the question of the establishment of a medical insurance agency had been considered (see THE MEDICAL JOURNAL OF AUSTRALIA, March 15, 1924, page 271) and it had been resolved to refer this matter to the Branches. This had been done and further inquiry had been made in regard to the action that had been taken in New Zealand. It was pointed out that the object in view, namely the provision of life, accident, sickness, fire, burglary, motor car and other household insurances, at lower rates than those obtaining in the ordinary market, could be effected either through an agency as was being done in England or through an incorporated company as had been done in New Zealand. Many details were considered and it was finally resolved that Dr. R. H. Todd and Dr. J. Adam Dick be authorized to take the necessary steps as promoters for the formation of a medical insurance company.

Acquisition of Land for the British Medical Association in Federal Capital Territory.

Inquiries had been made at the instigation of Dr. J. Adam Dick concerning the possibility of acquiring land in the Federal Capital territory for the British Medical Association. It was thought that the Association might wish to build its house in the capital city at a later date. Regulations were in existence under the City Leases Ordinances which provided for the purchasing of leasehold land on a ninety-nine years' tenure, with the obligation of building within one year from the date of purchase. It had, however, been ascertained that the authorities might entertain a proposal to reserve a block of land of two or more acres for the erection of scientific institutions. It was resolved to make a definite application for this to be done and to add to this application the request for a further reservation of portion of this block for medical institutions.

Homœopathic Practitioners.

The following resolution of the Victorian Branch was submitted for the consideration of the Federal Committee:

> That in view of the fact that homœopathic practitioners are accepted as members of the British Medical Association in England and must, if they come to Australia, be admitted automatically to membership of the local Branches, the Federal Committee be requested to consider the possibility and advisability of electing homœopathic practitioners as members of this Branch.

It was noted that the Victorian Branch had previously adopted the following:

> The "Principles of Medical Ethics" regarding homœopathic practitioners shall not apply to resident medical officers of the Melbourne Homœopathic Hospital who are members of the British Medical Association.

These resolutions had been sent to the Branches and only the New South Wales Branch had sent a reply. The New South Wales Branch suggested that it did not think it necessary to alter the rules of the Federal Committee. In the Annual Handbook of the British Medical Association the matter was set out succinctly. In 1906 the Central Ethical Committee in its report to the Representative Body pointed out that the only rule bearing on this subject was that it was the duty of a practitioner to refuse to meet in consultation a practitioner whose exclusive profession of any peculiar system of treatment would render consultation futile. The Representative Body in 1910 had resolved that the Association should not pronounce in connexion with what constitutes sound doctrine in medicine or surgery, that it was contrary to the recognized principles of professional conduct for any medical practitioner to advertise the holding of peculiar views of pathology or treatment or the fact that his practice is based thereon, as a means of attracting to himself patients and that it was desirable that the bodies which have the power of electing members of the Association, should not elect those who are reasonably believed to act unprofessionally in any of the ways stated and that concerning those who are already members, the disciplinary powers of the Council and of the Branches should be duly exercised if and when cases of the kind are brought under their notice in conformity with the ordinary rules of procedure of the Association in ethical matters.

DR. J. LOCKHART GIBSON informed the Committee that the Queensland Branch were strongly opposed to the admission of homœopathic practitioners on the ground that no one in these days could honestly hold such views.

DR. GREGORY SPROTT stated that the Tasmanian Branch held that it was unethical for a practitioner to call himself a homœopath.

The findings of the Represenative Body were duly noted and it was decided that it was not advisable to alter the practice obtaining in this regard.

Commonwealth Laboratories.

DR. GREGORY SPROTT moved on behalf of the Tasmanian Branch:

> That the Federal Committee objects to the institution of Commonwealth laboratories which enter into competition with private laboratories.

He pointed out that the Branch had approved of the establishment of a private laboratory by a reliable practitioner to serve the needs of the medical profession in Hobart. It was felt that this practitioner would be placed at a great disadvantage if the Commonwealth Department of Health were to institute one of their laboratories to compete with this practitioner. They had been informed that such a laboratory was about to be established.

It was pointed out that the institution of public laboratories by the Commonwealth Department of Health was a matter of public utility and had the approval of the Federal Committee. It was suggested that the Tasmanian Branch communicate with the Director-General of Health to ascertain what could be done with the view to the interests of private practitioners not being interfered with.

Date of Next Meeting.

It was resolved that the date of the next meeting be left in the hands of the Chairman. Dr. Gregory Sprott indicated that he would give notice to move an alteration of the rules to allow the meetings to be held in the spring and autumn instead of in February and July or August.

Votes of Thanks.

Cordial votes of thanks were passed to the Council of the New South Wales Branch for having provided accommodation and for having entertained the Committee at dinner, and to the Chairman, Sir George A. Syme, for the excellent manner in which he had conducted the meeting.

NATIONAL INSURANCE.

THE following is a *résumé* of the evidence given by DR. J. NEWMAN MORRIS, submitted by himself for publication at the request of the Federal Committee.

DR. J. NEWMAN MORRIS, Chairman of the Council of the Victorian Branch of the British Medical Association, stated that the objects of the British Medical Association were to promote the medical and allied sciences and to maintain

the honour and interests of the medical profession, to form a bond of union among the members of the profession and a medium through which their opinions could be easily ascertained and expressed, to advance the general and social interests of the profession, to promote fair and honourable practice, to suppress unqualified practice and to decide upon questions of professional usage and courtesy, to correspond with bodies or individuals on any matter touching medical interests and by moral influence and the exercise of a judicious supervision to prevent abuses in the profession, to consider any subject connected with the appointments of medical men to public institutions and services, to consider any question of medical polity, to further the federation of the medical profession in Australasia and to hold periodical meetings of members of the Association.

There were eleven hundred members in the Victorian Branch. There was only one Branch in Victoria. The disciplinary powers were those of any association. If the rules, regulations and principles were not followed, there was the right to determine a man's membership or the right to censure him, if it thought that expulsion was not necessary. If a man's membership was determined, he was not necessarily ostracized. If a doctor did not adhere to certain ethical principles and rules of profession practice, he was not met in consultation.

Arrangements with Friendly Societies.

The arrangements with friendly societies were governed by a common form of agreement which was based upon the findings of Judge Wasley who had sat as a Royal Commission some years previously. The agreement was signed between the governing body of each organization and the individual club doctor. It was ratified and countersigned by the Secretary in the office of the Victorian Branch and all the work was done under its terms. A member of a benefit society received medical attention, as did also his dependants up to the age of sixteen years in the case of males and eighteen years in the case of females. For that service one pound a year was charged in metropolitan districts and in Bendigo, Geelong and Ballarat and 25s. in the other parts of Victoria. There was a certain income limit which applied to new members joining a society after June, 1921, but not to persons who had been members before that date. The agreement had been satisfactory some years previously; it was no longer a satisfactory one. It had been drawn up by them in 1913 and modified later by Judge Wasley. The terms which had been asked in 1913, had been asked in 1918, but not because they considered them adequate or reasonable, having regard to the changed circumstances of society. They thought that they were not satisfactory, mainly with regard to remuneration. The rate of 20s. *per annum* had been asked for in 1913. It had never been agreed to by the friendly societies. In 1913 the average rate had been 14s. *per annum*. An organized claim for 20s. had been made in 1913, but claims had been made before that. The increase had not taken place till 1920, but Judge Wasley had given his ruling in 1918. About 41% of the members were working under this agreement. There had not been many requests for alterations in the agreement from those members, but the Council had recently sent out a *questionnaire*, the replies to which had given a definite indication that the present rates of remuneration were not satisfactory. They had also had individual expressions of opinion.

The Attitude of the Victorian Branch to National Insurance.

About one hundred and sixty replies had been received, most of which were from lodge medical officers.

Asked what was the attitude of the Victorian Branch of the British Medical Association towards a scheme of national insurance, witness said that the Victorian Branch was opposed to the introduction of any known scheme of national insurance at present in operation. This body was in sympathy with every effort that was made to improve the health of the nation, if these efforts were on the right lines. If the purpose of a Commonwealth Government scheme was merely to provide compulsory facilities for ordinary medical treatment for certain sections of the community, they were not in favour of it, because ordinary medical treatment was available for every member of the community. No one in need of treatment was refused it. The only exceptions were in scattered rural districts where distance from medical aid was great and no scheme of insurance could cover that. If, however, a scheme were evolved having for its purpose that preventive measures should be taken in all sorts of directions, that tuberculosis and venereal disease should be stamped out, that public health authorities should be kept up to the mark, that proper facilities for diagnosis, consultation and treatment should be available in all areas, that no one should go without skilled medical treatment for lack of means nor be without help when incapacitated, then the Victorian Branch would help, provided that such a scheme was safeguarded against becoming the prey of politicians and that the traditional independence of the medical profession was not destroyed. They had felt that all the schemes which were in operation, were too much controlled by politicians. That had been one of the criticisms against the British act. It was administered by the Ministry of Health and officials appointed by him. The Ministry was constantly changing and there was a consequent uncertainty with regard to the position. One minister might have a good scheme, but it might be knocked down by another minister in the next year or the next week.

As a principle the arrangement with friendly societies was a good one. They had not any objection to a Government scheme *per se*, but they objected to an extension of contract practice broadcast throughout the land, because they held that contract practice or national insurance schemes were based upon an entire misconception of what contract practice was and should be. No contract practice provided for anything more than elementary medical treatment. Adequate medical treatment for the average citizen would provide facilities for the proper investigation of a man's complaint and not merely for domiciliary treatment and attendance. There should be laboratories and proper schemes for diagnosing a man's complaint and then proper treatment following available for everyone in the community. If such a scheme were accepted by the Government, they would have no objection and would be prepared to assist in the formulation of the scheme and the Victorian Branch would be whole-heartedly behind it.

Criticism of English Act.

Asked if he knew the English act, witness said he had tried to understand it. The whole of the act, as it stood, was probably inapplicable to Australia. He had gone through the act carefully and it appeared to him that it was a financial and not a health one. The only mention of prevention that he could find was in the title. One provision which approached prevention, was that the local insurance committees were to provide for the education of the people in their districts by means of health lectures and so forth, but it was well known that it was not done. The insurance committee did not carry out the work which they were asked to do under the act. The only other preventive provision was one which provided for investigation into the circumstances where there had apparently been an excessive amount of disease associated with factories or other places, when the responsibility was placed upon the people conducting the business. That was also a dead letter, as far as the act was concerned. With regard to the applicability of the act to Australia, the conditions in England as well as those in the continental countries were so different from those in Australia that such an act would not apply. There were no large classes of poor people in Australia, who were unable to obtain medical treatment. There was a very large percentage of intermediate people and a scheme of national insurance on the lines mentioned was desirable in the interests of those people, a scheme which would provide for the proper investigation of their complaints and for intermediate hospital treatment. The Victorian Branch realized that it was only the very poor and the extremely rich who were today able to obtain adequate medical treatment and they had drawn up definite lines of policy to provide for it. They had stated their attitude towards intermediate hospitals to the Victorian State Government. The conditions

which had been approved by the Council of the Victorian Branch in regard to the proposed establishment of intermediate hospitals by the State Government, were as follows:

An essential condition to any approval by the Council should be the cessation of the present system of levying monetary contributions from the patients of the public hospitals. It should be insisted that in-patients should be limited to voluntary contributions of not more than £1 per week towards the cost of their maintenance in hospitals. Patients should be aware that contributions were not expected from those who were destitute or who could not afford to contribute anything towards the cost of their maintenance, medicines and dressings. Hospital authorities should make it clear to patients that no portion of the monetary contributions was paid to the honorary medical staff. Given these essential conditions, the Council would approve of the establishment and maintenance of intermediate hospitals by the Government under the following conditions: (i.) Adequate representation on the board of control, these representatives to be approved by the Council of the Victorian Branch of the British Medical Association. (ii.) No medical staff to be appointed, but any medical practitioner to be permitted to send in patients and attend them. Expert radiology and clinical pathology should be provided and it might be necessary to appoint a resident medical officer or officers who should act as house surgeon and physician, but who should not treat patients except under the direction of some practising medical man. (iii.) No patient should be admitted without first producing a certificate of suitability for admission from a medical practitioner, who should wherever possible be the patient's usual medical attendant. If the signatory be not the patient's usual medical attendant, an explanation of the fact should be appended to the certificate. The question of suitability of patients for admission should be subject to review by the Board. (iv.) There should be no out-patients. (v.) There should be only one class of accommodation and uniform hospital charges, but suitable accommodation should be made for children. Regarding a scale of fees, the more the question of an inclusive fee was discussed, the more it became evident that the only satisfactory solution was that medical and surgical fees should remain a matter for mutual arrangement between the medical man and the patient. The medical and surgical fees to be adopted for any intermediate hospital established by the Government should be similar to those which had already proved to be satisfactory in the existing intermediate hospitals. A definite scale of maximum medical and surgical fees for intermediate patients in country hospitals was being drawn up. It was desired to make it as compresensive as possible and it was being found a work of much difficulty. When finally approved, it would become a standard scale for its purpose. Patients should not be entitled to treatment under the scale of fees if their income exceeded the limit in the common form of agreement with friendly societies. The Council was of the opinion that authority for intermediate wards in public hospitals should not be applied to large centres, such as Ballarat, Bendigo and Geelong.

Intermediate hospital treatment was just as subject to abuse as public hospital treatment. People who could afford to pay for private hospital treatment, could go into intermediate hospitals, just as they could go into public hospitals.

Fixed hospital charges were made for intermediate treatment and the medical charges were governed by a scale for intermediate patients. Asked if he knew the principle in vogue at Dr. Mayo's clinics in America, witness replied that the proposal of the Victorian Branch was very much on the same lines, except that a definite limit was fixed, but that limit was not urged. If the income limit was not fixed, there would be abuse. If people with an income of £1,000 a year wanted treatment in an intermediate hospital, they could be shown the conditions under which treatment was given. The treatment of intermediate patients was no different from that of any other class of patient. Witness did not think that it would be better to have a scheme under which a man paid what he could afford, because that principle was adopted in public hospitals at present. The system was abused by the officials of the hospitals, who did not keep a sufficient check. A man had been prosecuted and fined for abusing the attendance at the Melbourne Hospital and it had been reported in the paper that the Secretary of the Hospital had stated that "if he had known his circumstances they would have charged £3 10s. per week for maintenance." He thought such cases are general. They might not occur under a national insurance scheme, if sufficient supervision were exercised. The success of a scheme of national insurance depended on supervision and administration.

Objections to British Act.

Asked if there were any regulations under the British act which he thought were not suitable to Australian conditions or which worked harshly upon the profession, witness said there were quite a number. The act was a financial one, over-burdened with its relationship to friendly societies and approved societies and the whole act seemed to be drawn up with due respect to them. The societies insisted upon seven forms of certificates which were intended to guard their funds against abuse. The requirements with regard to certification had become so elaborate that they were an oppression to the medical profession. They were all important from the standpoint of the societies, but they did not enable a sick man to get any better treatment. They did not suggest that the certificates were unnecessary, but seven different forms were too many. A uniform system might meet this objection, but he had not considered any definite proposals as to what certification was necessary. The basis of the act was with regard to health matters and provision for medical attention and medicines. That was referred to in many sections of the act, but the only definition given was practically such service as a medical practitioner of ordinary competence and skill could give. There was no provision at all for the treatment which a man needed. He did not receive a complete medical service. There were additional benefits provided to be granted or arranged for by the approved societies out of their spare funds, but those benefits very seldom provided additional treatment in any way. They provided additional financial benefits, but not medical treatment.

The term was much too elastic. Adequate medical treatment should be very definitely defined and made the basis of a national insurance scheme and a complete medical service should be arranged for right at the commencement. If the Victorian Branch of the British Medical Association were asked to formulate a scheme, they would draw up what they considered was a suitable one and submit it to the Federal Committee which should speak for the whole of Australia.

Witness denied that the British Medical Association was a trades' union. On the question of refusing to consult with another medical man, he said that everybody had liberty of action. A doctor would be seriously handicapped but not ruined if he could not consult with his brother practitioners.

Medical Taxing Officer.

In the event of a national insurance scheme being introduced, it would be necessary for the Government to provide a more or less elastic scale of charges. He did not think it would be right to have a medical taxing officer. His Branch Council had said that it was not in favour of a taxing officer.

Asked why there were one hundred doctors in Victoria who were not members of the British Medical Association, witness said that some were ineligible, some had retired from practice and some did not wish to be members. Certain doctors were not eligible because they had contravened the ethics of the Association or the rules and regulations of the Association. They had accepted rates of pay lower than those recognized as the standard rates for contract work in certain districts.

Basis of Friendly Society Contract Work.

Asked by the Chairman how the rate of one pound per member *per annum* provided in the agreement was computed, witness said it had been fixed largely because it was the rate which had been accepted in New South

Wales and they desired to make the rate uniform throughout Australia. Judge Wasley had fixed it because they had been asking for it and would not accept anything else. The figure had not been fixed on a case basis. The average payment for attendance prior to that time had been about one shilling. In some districts it was ten pence and in others one shilling and three pence. The average number of visits made by a medical man to friendly society members was from ten to fifteen a year. The figures included a member, his wife and family. The average number of visits *per annum* under the British scheme was three visits.

Under the common agreement with friendly societies there was no arrangement made for payment by juniors. A person might join a lodge at the age of sixteen. The same rate was paid throughout. The only difference was that the single females paid twelve shillings. He considered that quite an equitable agreement because the twenty shillings did not pay for a family and the juniors or minors made the work pay a little more. It was not merely for the purpose of striking an average. Friendly society work was regarded as insurance work. A man did not pay so much *per annum* for attendance, but in order to insure himself, in the same way as he did against fire. He did not pay one pound and receive one pound's worth of attendance. He might be in a lodge for ten or twenty years before he derived any benefit from the payment. About 90% of lodge members joined friendly societies because they had in mind the fact that they would require medical service. Contract practice as it existed in Victoria was sufficient only as far as ordinary medical treatment was concerned. The agreement did not provide for anything of a surgical nature, requiring an operation under an anæsthetic. Contract practice should really carry over to an institutional practice. The Council of the Branch had not made any definite suggestion in that regard, but they thought that a scheme which was going to provide for medical treatment, should provide for the most complete medical treatment that any member of the community needed. But there were details as to how the scheme would be managed and as to whether there should be intermediate hospitals or Government hospitals or national insurance hospitals. Adequate medical attendance would not be given to any person when there was not an opportunity of following on to a hospital. The present practice was inadequate. All patients with severe medical illness required nursing. In regard to the case of a man with an obscure complaint, which had to be investigated, there was no provision whatever for an investigation under ordinary contract practice, any more than there was for surgical treatment. Many things had to be done and a patient with an obscure illness might come in once, twice or three times a day. Under ordinary circumstances such a patient did not receive medical treatment as they understood it. The man was examined in a routine sort of way, if there was time to do so, but the rates of pay did not allow time, if the practitioner had a large practice, which made lodge work worth while financially. The practitioner could not devote adequate time and attention to the patient nor was provision made for adequate investigation. There were many routine measures, as well as measures which were not routine, in connexion with an investigation. Quite apart from ordinary panel practice, there would have to be provision for a radiological, bacteriological and pathological treatment, as well as hospital treatment, in order to have a complete whole in every district.

Size of Panel.

Asked how many patients a doctor could adequately attend and what would be the maximum number he could have on his list, witness said that that question could be answered by saying how many a man could see adequately in a day. He had had to give up lodge practice when he had a list of five hundred members. He had felt that he could not attend to them adequately and properly. Five hundred would mean five thousand visits *per annum* or about fifteen or sixteen patients a day. Five hundred members were equivalent to two thousand individuals. It would be necessary to look forward to treating fifteen or sixteen contract patients each day.

Inclusion of Dependants.

Asked if under a scheme of national insurance he thought that the present system of friendly society practice should be continued or that the numbers should be calculated on a unitary basis, witness said his Branch had not considered the matter. A national health insurance scheme presumably would be based on the provision of the health requisites of the wage earning classes in an endeavour to increase their efficiency and to get them back to work as quickly as possible when they were ill. No national scheme, however, provided for dependants as an essential part of it. If the basis of payment was one in which the employer had to share, he could not be asked to pay for his employee's wife and children. His own view was that dependants should be included in a complete scheme.

Basis of Payment.

Asked what would be the position of the profession in Victoria if the remuneration were fixed on a similar basis to that of the English scheme, he said that as a basis of payment nine shillings *per annum* per individual would be better than the present lodge rates. If they were paid on a basis of thirty-six shillings for each family, it would probably be a fairly acceptable basis. It was the highest rate paid in Australia at the present time. He thought that a case rate would be preferable to a contract rate. The remuneration per case would be difficult to fix. On the basis of the present intermediate rate of pay, the Branch had adopted a scale of fees. For some years there had been on the scale of fees a provision that an intermediate rate should not exceed 75% of the lowest figure on the scale, which was a sliding scale. He thought that a basis per attendance which approached the intermediate scale, would be a satisfactory one.

A National Insurance Pharmacopœia.

Asked if it would be possible for a pharmacopœia to be printed, something like the Melbourne Pharmacopœia and formulæ for use in connexion with a national insurance scheme, he said he thought it could be done and it would be of use in ordinary cases. Extraordinary cases would have to be dealt with on their merits. Something of that kind would have to be done in order that a national insurance scheme could be run on economic lines and to provide a proper basis for calculations.

Friendly Society Control of National Insurance.

Asked if he had considered the system of approved societies in relation to a national insurance scheme, he said the Branch was opposed to any sort of control over such a scheme being placed in the hands of approved societies in Australia. The Council had not considered any system of grouping friendly societies similar to the Friendly Societies' Association which was in existence at present, with a committee including members of the Branch of the Association. The position was that the medical profession was working under good friendly arrangements with the friendly societies and matters were going along smoothly, but all the same they had noticed in the ranks of friendly societies and amongst the leaders of those societies an utter inability to comprehend fully the essentials of medical practice. Friendly societies seemed to be from fifty to one hundred years behind the times in their knowledge of medical practice and their whole attitude appeared to be centred around a desire to get the cheapest possible medical attention. One member of a friendly society had actually said in the course of a conference with the Branch: "We do not expect to get the best men to do friendly society work." His remark bore out the contention that the friendly societies were out to get control and the cheapest attention all the time. That was an ideal at which a national insurance scheme would not aim and the medical profession would never consider any scheme that would not attract the best of their men. The British Medical Association would be opposed to any arrangement which provided for friendly societies to be approved societies with power over the medical profession and would be opposed to any national insurance scheme giving friendly societies even that power over the profession which the societies had.

Preventive Measures in National Insurance.

Asked how he would suggest that the prevention of disease should be dealt with in a scheme of national insurance, witness said that one of the essential things in the prevention of disease was to include in the preventive work every medical practitioner in the country; every man carrying on curative treatment should be regarded as part of the preventive scheme; he should have certain duties to perform and should be remunerated for such duties, at the same time being penalized for any neglect to carry them out. The Federal Committee of the British Medical Association had adopted a scheme embodying that principle of prevention which could be very easily included in any scheme of national insurance and which had been put forward as expressing an opinion of the Association in Australia. Included in the scheme was provision for adequate inspection of school children; they felt that there was great need for the education of the individual. That education should be started from childhood. No scheme of prevention could be regarded as complete unless something like that were provided. It was, in his opinion, essential. Dental treatment should be regarded as essential also.

Defects of Contract Practice.

He would like to say with regard to contract practice that there was a general misconception in regard to the system of contract practice. The general tendency of friendly societies at the present time was to lower the standard of service. Contract practice had always excluded men in the higher ranks of the medical profession, such as consultants, specialists and men of that type who had never taken on contract work. The opinion of his Council was that contract practice endangered the patient's right to efficient treatment and at the same time resulted in overwork as far as the doctor himself was concerned, while embracing only elementary routine work. They thought that every effort should be made to avoid anything which tended to lower the standard of living of medical men generally; without any egotism at all they held that the standard of living amongst doctors should remain high, mainly for the benefit of the people whom they served; doctors should not be overworked, because their duties covered twenty-four hours of the day for seven days a week and therefore every facility for rest should be given them. They also held that they should receive as recompense for their work remuneration sufficient to provide money for books and facilities for treating their patients. That state of affairs did not exist. There should also be an arrangement to provide the doctor with sufficient time for study and recreation and for reading. He could not say what percentage actually read, but he knew that the several circulating libraries were very well patronized by members of the Branch and the discussions which took place at meetings of members of the Branch showed that members had been reading up on various subjects. The discussions would be limited to members attending the meetings. He would not say that every member of the Branch read. There should also be provision for post-graduate study. Travel courses were also of great benefit to members of the profession, but medical men had neither the leisure time nor the money to spend on travel courses. The more contract work was extended, the less opportunity would be given to the medical man for study and for leisure and therefore the less opportunity offered for progress to be made. It was a well-known fact, disclosed by insurance statistics, that the average length of life of medical men was on the low side, compared with the average length of life of other members of the community. The tendency among friendly societies was to cheapen the rate of payment to doctors in order that sickness benefits and funeral benefits might be increased. Over and over again in England, Germany and Australia doctors had found it necessary to unite in order to oppose concerted attempts to cheapen the payment made for medical attention. These attempts on the part of friendly societies had caused a feeling of unrest amongst doctors engaged in contract practice. The duties of contract practitioners comprised diagnosis, treatment and prevention and there was no getting away from the fact that with a cheap rate of remuneration the medical man must take a very large number of patients on his list on the contract system in order to obtain adequate remuneration. A medical practitioner under existing conditions could not treat as many patients as it was possible to deal with under the old conditions. Medicine had become a science as well as an art and one must have time to study the science, as well as facilities to practise the art. Witness did not think it would be possible to carry out contract practice without laboratories which were absolutely essential. Adequate time must be given to medical men to carry out a proper diagnosis of each case. With a new patient from half an hour to an hour was necessary for diagnosis, depending upon the type of case. He remembered on one occasion when he was engaged upon lodge work, having to spend three-quarters of an hour over one lodge patient. He had a room full of other patients waiting attention and the man who came into his surgery after the patient on whom he had spent three-quarters of an hour had left, demanded that he should be treated as a private patient. Witness asked him what he meant and he said that the first man had taken up so much time, that he thought it would be as well to pay for the extra time necessary to receive adequate treatment. He told him that the first patient was a contract patient and he had found it necessary to spend three-quarters of an hour upon him. That conversation, however, showed that contract patients did not expect very much in many instances; they were satisfied with a quick diagnosis and a bottle of medicine. But that sort of thing, of course, could not be regarded as satisfactory from the point of view of the medical man. Not only must the history of the case be made clear and notes be taken, but there were also certain routine tests which were essential. A proper diagnosis could not be made in five minutes and two or three patients might mean a couple of hours of laboratory work. Therefore, it was necessary to reduce the number of patients in order to give the remainder adequate treatment. In order that the most efficient work might be done in safeguarding the health of the community, he would suggest that laboratory equipment and laboratory personnel should be under the control of a committee composed exclusively of medical practitioners and that all regulations should be drawn up by that committee which in turn would be responsible to a higher administrative committee. In the opinion of the Branch all regulations controlling or affecting medical men should be left in the hands of a committee composed only of medical men. In using the term "medical men" he did not mean only general medical practitioners. He would use the term "scientific men." As far as equipment was concerned, the Government was in a much better position than anybody else to provide equipment to individual members of the profession. The providing of proper laboratory equipment was a very expensive proposition and it was an even more expensive proposition to maintain that equipment. Therefore, it would be more economical for the Government to provide laboratory equipment and to charge for the services rendered in any way that might be thought fit. The personnel on the medical side should be free of any direct State control and should be adequately remunerated in order that the best traditions of the profession might be maintained. He would like to direct the attention of the Commission to the remarks of Sir Clifford Allbutt in regard to contract practice as laying down the ideal which should be aimed at by everybody.

It was necessary that certain principles of relationship between the doctor and his patient should be maintained. There should be confidence on the part of the patient in the skill of the doctor and the doctor must give adequate care and skill. His Branch had made inquiries with regard to the number of people in different districts unable to obtain medical treatment and the replies received were practically unanimous on the point that there was nobody who was unable to obtain medical treatment. He had not gone into the question of the number of inhabitants per medical man, but the number of lodge patients that a doctor had on his list, depended on the rate of remuneration. If that rate were low, of course, he must take a large number in order to receive anything like adequate remuneration. The standard of work would

undoubtedly be raised, from that point of view, if the rate of remuneration became more reasonable. He had not said that everybody was able to obtain medical treatment.

Ante-Natal Treatment in National Insurance.

Asked for an opinion with regard to the provision of better facilities for the treatment of women during the period of child-birth and if he considered that they did get adequate treatment, he said that they did not get sufficient treatment, although there were ante-natal clinics at the Women's Hospital and at the Queen Victoria Hospital. Ante-natal treatment was essential in connexion with midwifery, but he would not say that women throughout Victoria, generally speaking, got either sufficient or efficient ante-natal supervision. Under a scheme of national insurance adequate provision should be made in the direction of providing better facilities for the treatment of women during maternity; he would have maternity hospitals quite apart from other hospitals. If a national insurance scheme made provision in that direction, he was sure it would result in bringing down the death rate among infants.

NOMINATIONS AND ELECTIONS.

THE undermentioned have been nominated for election as members of the New South Wales Branch of the British Medical Association:

ARRATTA, JOSEPH ANDREW, M.B., 1922 (Univ. Sydney), 5, Arcadia Road, Glebe.

BRAY, MABEL IRENE COUSAN, M.B., Ch.M., 1922 (Univ. Sydney), Cassilis.

MAIN, ARTHUR WAREHAM, M.B., Ch.M., 1924 (Univ. Sydney), Longueville Road, Lane Cove.

THE undermentioned have been elected members of the New South Wales Branch of the British Medical Association:

ARMSTRONG, EDWARD PATRICK, M.B., Ch.M., 1922 (Univ. Sydney), Butchers' Arms Hotel, Pyrmont.

BANCROFT, MABEL JOSEPHINE, M.B., 1924 (Univ. Sydney), Royal Prince Alfred Hospital, Camperdown.

DINLEY, ROY PATRICK JOSEPH, M.B., Ch.M., 1922 (Univ. Sydney), Unwin's Bridge Road, Sydenham.

HAMILTON, THOMAS, M.B., Ch.M., 1922 (Univ. Sydney), Newcastle Hospital, Newcastle.

HYNDES, PAUL FRANCIS, M.B., 1924 (Univ. Sydney), 428, Marrickville Road, Marrickville.

PATON, CLIVE NINESS, M.B., Ch.M., 1922 Univ. (Sydney), Royal Prince Alfred Hospital, Camperdown.

THE undermentioned has been elected a member of the Victorian Branch of the British Medical Association:

PLOWMAN, SIDNEY, M.B., B.S., 1923 (Univ. Melbourne), The Lofts, Frankston.

THE undermentioned have been elected members of the Queensland Branch of the British Medical Association:

BYRNE, CHARLES, M.B., B.S., 1923 (Univ. Mlbourne), Brisbane.

CHAUNCEY, JAMES HORNIDGE, M.R.C.S. (Eng.), L.R.C.P. (Lond.), 1904, Brisbane.

GILLIES, CLYDE DOUGLAS, M.B., B.S., 1924 (Univ. Melbourne), Brisbane.

SUNDSTRUP, HENRY ARTHUR, M.B., Ch.M., 1924 (Univ. Sydney), Brisbane.

WAGNER, JOHN GEORGE, M.B., Ch.M., 1924 (Univ. Sydney), Brisbane.

THE MEDICAL BENEVOLENT FUND OF NEW SOUTH WALES.

A MEETING of the Council of the Medical Benevolent Fund of New South Wales was held on July 17, 1924, Dr. R. L. Faithfull in the chair.

An application was received from the widow of a medical man formerly practising in the country for the maintenance of two boys, aged eleven and nine and a half years, at school. The mother is entirely without means and maintains herself and a little girl by nursing at a private hospital. It was decided to give the mother assistance for the support of each child up to January 1, 1925, and further assistance provided that funds would be available.

It was further decided that members of the New South Wales Branch of the British Medical Association should be invited to subscribe to the Fund. Subscriptions (10s. 6d.) should be sent to the Honorary Secretary, Dr. E. S. Littlejohn, B.M.A. Building, 30 to 34, Elizabeth Street, Sydney.

Correspondence.

DIATHERMY IN STERILITY.

SIR: The following case may be of some interest to gynæcologists and the profession generally.

A Mrs. A., aged about thirty-seven years, married five years without issue; husband apparently healthy in every way; Mrs. A. herself was a healthy well-formed woman, but complained of some dysmenorrhœa, a fair amount of leucorrhœa and frequent menstruation (twenty-one days' intervals).

When first she consulted me, I advised her to see a gynæcologist, which she did. The diagnosis was plugging of cervix by acid discharge and she was treated for some months. Getting little or no relief she consulted another gynæcological surgeon, who operated, curetting the uterus and dilating the cervix *et cetera*. After waiting for eighteen months and feeling no change for the better she consulted me. In course of conversation I found that some years before marriage she suffered from a severe attack of mumps followed by pelvic peritonitis and ovaritis on both sides. This gave me the idea that intra-pelvic adhesions, especially between tubes and ovaries, were the cause of her sterility. I advised and gave her a course of diathermy from foot to foot for nearly two months. Her first period was free from pain; the leucorrhœa cleared up; the time had increased to twenty-eight days. As her next period did not appear at the usual time, I abandoned treatment. She was pregnant and a week ago was delivered of a healthy male infant.

In conclusion, I must say that I am firmly convinced of the efficacy of the diathermic current in this case, especially since long and varied use of diathermy by myself and others in various forms of abdominal trouble from adhesions, especially after operations on the gall bladder, stomach and duodenum, has proved that it gives complete relief when all other treatments fail.

Yours, etc.,
J. F. NELLY,
Honorary Director, Electro-Therapeutic Staff, St. Vincent's Hospital, Melbourne.

July 3, 1924.

Obituary.

THE LATE EDWARD HENRY EMBLEY.

DR. R. A. STIRLING writes:

"I first met Dr. E. H. Embley when he was a particularly earnest student at the Melbourne Hospital. Later on when he started practice in Latrobe Street we became intimately connected in work. As an anæsthetist he was for many years in great request, not only in difficult cases by many surgeons outside the hospital, but by nearly everyone within. It was always a marvel to me how he was able to do a very large consulting and visiting practice and yet spend several afternoons a week inculcating upon the minds of the senior students of the many various years the science and practice of anæsthetics.

He gave time, knowledge, service and assistance to his fellows always ungrudgingly. I never knew him to refuse

a night or early morning call to the hospital, nor to a private patient and he often used to assert smilingly that two or three hours of absolutely sound sleep were equal to the usual quota.

Besides his special work in his own own department he had one absorbing passion which occupied every spare hour—research in the physiological laboratory at the Melbourne University, which, though lethal enough to an occasional stray mongrel, has saved many a human life.

His explanation of the generally quite hopeless "primary chloroform collapse" and heart failure (in diastole) is, I believe, accepted as correct, although some think that ventricular fibrillation is the cause of the sudden death. He thought it due to a reflex arrest of the heart from the irritant action of the chloroform on the mucous membranes. "A normal heart reacts to such a reflex check with merely a slowing of the pulse or at most a stoppage of a few seconds, but the slight depression attending even the commencement of anæsthesia may prevent it starting again."

He retired from active work in November, 1920, as a result of a painful illness which he bore without complaint. Of a most urbane and amiable disposition, gentle and retiring, he had the one great virtue of a good anæsthetist—an unruffled courage even in the greatest emergencies.

LOUIS BIRCH.

IT is with regret that we have to announce the death of Dr. Louis Birch which occurred at Tweed Heads, New South Wales, on July 13, 1924.

LOUIS HENRY.

WE regret to announce the death of Dr. Louis Henry which occurred at St. Kilda, Victoria, on July 18, 1924.

Books Received.

AN OUTLINE OF ENDOCRINOLOGY, by W. M. Crofton, B.A., M.D.; 1924. Edinburgh: E. & S. Livingstone; Crown 8vo., pp. 134, with 50 illustrations. Price: 6s. net.

HANDBOOK OF SKIN DISEASES, by Frederick Gardiner, M.D., B.Sc. (Public Health), F.R.C.S.E., F.R.S.E.; Second Edition; 1924. Edinburgh: E. & S. Livingstone; Crown 8vo., pp. 248, with 46 illustrations in the text and 12 coloured plates. Price: 10s. 6d. net.

HEALTH PROBLEMS OF THE EMPIRE, PAST, PRESENT AND FUTURE, by Andrew Balfour, C.B., C.M.G., M.D., B.Sc., D.P.H., F.R.C.P.E., and Henry Harold Scott, M.D., M.R.C.P. (Eng.), D.P.H., D.T.M. (Cam.), F.R.S.E.; 1924. London: W. Collins, Sons and Company, Limited; Demy 8vo., pp. 433, with nine illustrations. Price: 16s. net.

INSANITY AND LAW: A TREATISE ON FORENSIC PSYCHIATRY, by H. Douglas Singer, M.D., M.R.C.P. (Lond.), and William O. Krohn, A.M., M.D., Ph.D.; 1924. P. Blakiston's Son and Company; Post 8vo., pp. 437. Price: $6.00.

SUPPLEMENT 1921-1923 TO THE CATALOGUE OF LEWIS'S MEDICAL AND SCIENTIFIC CIRCULATING LIBRARY WITH INDEX OF SUBJECTS AND AUTHORS; Demy 8vo., paper cover; pp. 86. Price: 1s. net.

THE CIRCULATORY DISTURBANCES OF THE EXTREMITIES INCLUDING GANGRENE, VASOMOTOR AND TROPHIC DISEASES, by Leo Buerger, M.A., M.D.; 1924. Philadelphia and London: W. B. Saunders Company; Melbourne: James Little; Royal 8vo., pp. 640, with 188 figures. Price: 45s. net.

TRANSACTIONS OF THE AMERICAN PROTOCOLOGIC SOCIETY: TWENTY-FOURTH ANNUAL SESSION (JUNE, 1923); 1924. New York: Paul B. Hoeber, Inc.; Royal 8vo., pp. 89, illustrated. Price: $3.00.

Medical Appointments Vacant, etc.

FOR announcements of medical appointments vacant, assistants, *locum tenentes* sought, etc., see "Advertiser," page xvi..

MATER MISERICORDIÆ HOSPITAL, BRISBANE: (*a*) Honorary Assistant Surgeon (Out-Patient Department); (*b*) Honorary Assistant Ophthalmic Surgeon.

Medical Appointments: Important Notice.

MEDICAL practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429, Strand, London, W.C..

BRANCH.	APPOINTMENTS.
NEW SOUTH WALES: Honorary Secretary, 30 - 34, Elizabeth Street, Sydney.	Australian Natives' Association. Ashfield and District Friendly Societies' Dispensary. Balmain United Friendly Societies' Dispensary. Friendly Society Lodges at Casino. Leichhardt and Petersham Dispensary. Manchester Unity Oddfellows' Medical Institute, Elizabeth Street, Sydney. Marrickville United Friendly Societies' Dispensary. North Sydney United Friendly Societies. People's Prudential Benefit Society. Phœnix Mutual Provident Society.
VICTORIA: Honorary Secretary, Medical Society Hall, East Melbourne.	All Institutes or Medical Dispensaries. Australian Prudential Association Proprietary, Limited Mutual National Provident Club. National Provident Association.
QUEENSLAND: Honorary Secretary, B. M. A. Building, Adelaide Street, Brisbane.	Brisbane United Friendly Society Institute. Stannary Hills Hospital.
SOUTH AUSTRALIA: Honorary Secretary, 12, North Terrace, Adelaide.	Contract Practice Appointments at Renmark. Contract Practice Appointments in South Australia.
WESTERN AUSTRALIA: Honorary Secretary, Saint George's Terrace, Perth.	All Contract Practice Appointments in Western Australia.
NEW ZEALAND (WELLINGTON DIVISION): Honorary Secretary, Wellington.	Friendly Society Lodges, Wellington, New Zealand.

Diary for the Month.

AUG. 6.—Victorian Branch, B.M.A.: Branch.
AUG. 8.—Queensland Branch, B.M.A.: Council.
AUG. 12.—New South Wales Branch, B.M.A.: Ethics Committee.
AUG. 13.—Tasmanian Branch, B.M.A.: Branch.
AUG. 13.—Melbourne Pædiatric Society.
AUG. 13.—Central Northern Medical Association, New South Wales.
AUG. 14.—New South Wales Branch, B.M.A.: Clinical Meeting.
AUG. 14.—Victorian Branch, B.M.A.: Council.
AUG. 14.—South Australian Branch, B.M.A.: Council.
AUG. 14.—Brisbane Hospital for Sick Children: Clinical Meeting.
AUG. 19.—New South Wales Branch, B.M.A.: Executive and Finance Committee.
AUG. 19.—Illawarra Suburbs Medical Association, New South Wales.
AUG. 20.—Western Australian Branch, B.M.A.: Council.
AUG. 22.—Queensland Branch, B.M.A.: Council.
AUG. 26.—New South Wales Branch, B.M.A.: Medical Politics Committee; Organization and Science Committee.
AUG. 27.—Victorian Branch, B.M.A.: Council.
AUG. 28.—New South Wales Branch, B.M.A.: Branch.
AUG. 28.—South Australian Branch, B.M.A.: Branch.
AUG. 31.—Victorian Branch, B.M.A.: Notice *re* Election.

Editorial Notices.

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